

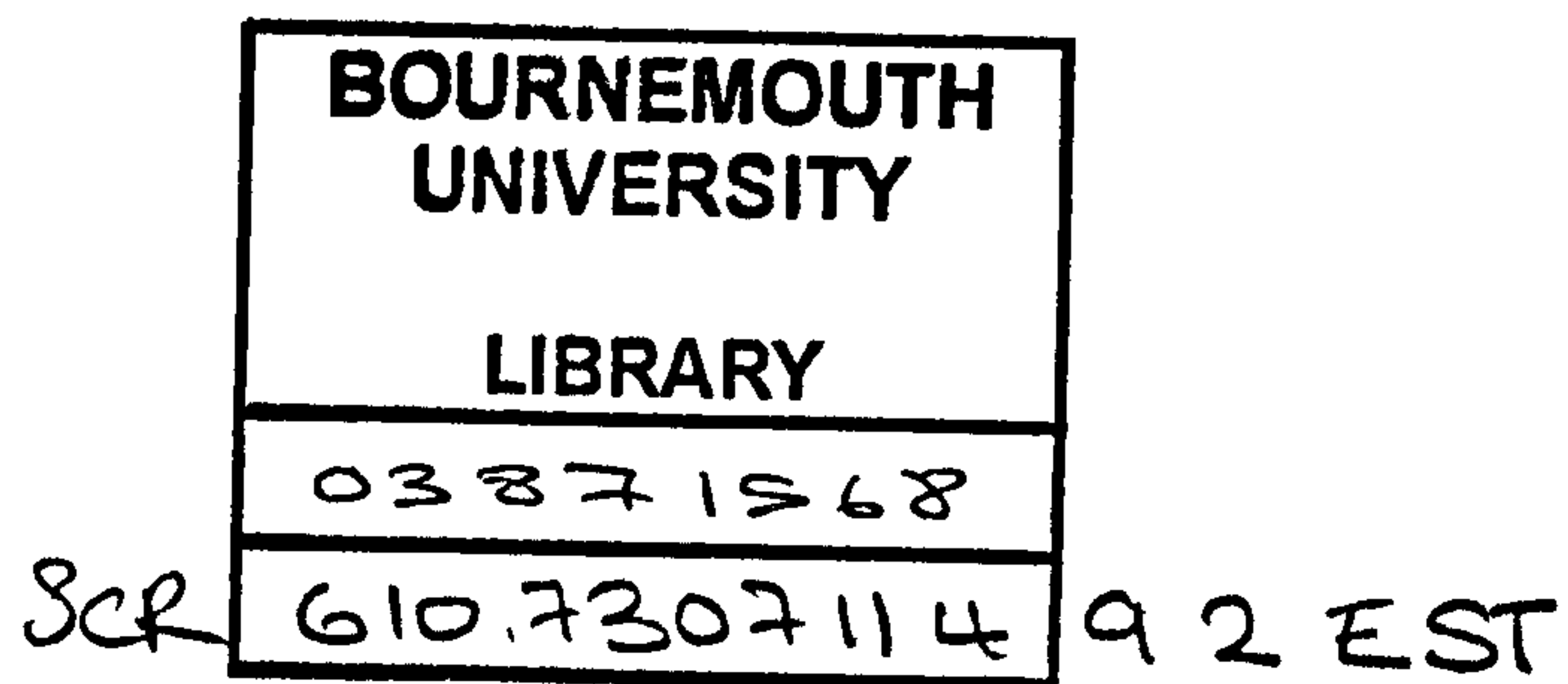
**THE JOURNEY FROM NEOPHYTE TO REGISTERED NURSE –  
A DUTCH EXPERIENCE**

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A thesis submitted in part fulfilment of the requirements of Bournemouth University for the  
degree of  
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## Abstract

### THE JOURNEY FROM NEOPHYTE TO REGISTERED NURSE – A DUTCH EXPERIENCE

by

Philip Esterhuizen

Case studies of five Dutch undergraduate students form the initial focus of this longitudinal study. An ethno-methodological approach was utilised to provide insight into how student nurses made sense of their social and personal reality and dealt with situations and challenges encountered during the four-year programme leading to registration as a degree nurse. The case studies are further examined within a meta-case study – this being the auto-ethnographic context of the researcher's role as a nurse, an educator and a researcher.

The study highlights the interface between sociology and education, and between power and authority, discussing the student journey in terms of Parsonian and confluent educational frameworks. The research findings also highlight student awareness in dealing with the challenges of practice and indicate that students are proactive, and use preconceived strategies to negotiate their way through their placements successfully.

Specifically a student, who dropped out of the programme, is the subject of a 'deviant' case study; her experience provides an interesting backdrop to the students who completed the programme. The researcher analyses and discusses the concept of 'deviance', questioning the appropriateness of this terminology.

The study provides some insights into the original research questions regarding student motivation on entering nursing; the development of a 'caring philosophy', the internalisation of professional values and the ability to integrate theory and practice. In addition the richness of the researcher/student interaction adds an extra dimension to the existing body of knowledge. This narrative account invites the reader to follow the researcher's thoughts and decision-making whilst it simultaneously challenges the reader to confront their personal history and beliefs.

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## **Preface**

As precursor to my thesis I would like to share the concerns and considerations I've had as a researcher. I feel it serves to place the study in context and offers signposting and preparation for the reader who shares in my journey.

In my work as a clinical educator and my dealings with undergraduates I became interested in understanding if, how and why, according to the literature I'd read, nursing students socialised into an oppressive nursing culture. I was curious about how it worked and how they coped with making sense of their reality to complete the programme and register as nurses.

My original approach to this study was, therefore, to conduct longitudinal research with a small group of undergraduate students using an ethno-methodological approach. Along the way, however, I realised that I wasn't able to remain objective in this process and a second, auto-ethnographic strand of my research developed and now provides a context for my participants' stories. The combination of research approaches altered the shape of my study quite dramatically and I had no idea where it would lead.

Looking back I have been able to answer my original research questions, but the five students involved in my research have been instrumental in changing the way I think about my role as a health-care professional. My changed attitude is a different outcome to the ones I originally set out to achieve. Again, I couldn't have known where this research project would take me at the outset four or five years ago.

I ask myself how the participants view the changed focus of my study ... whether the final product is totally different from what they'd expected (or had been led to believe) ... and whether, if they had had the benefit of hindsight, they would still have consented to participate. I am confident that they would still have been happy to participate. They have always been interested in how my study was progressing and I did, along the way, tell them a little about the changes occurring for me. However, I was reluctant to tell too much for fear of biasing the research as it was. I am aware that if I had discussed my changed thinking, attitude and approach, we would be reading a very different thesis. I have sent all the students a copy of my thesis together with an invitation to feed their thoughts back to me – these will either be included in a postscript to my thesis or provide the material for later publication.



The auto-ethnographic element of my study could be criticised as being self-indulgent and appealing to any voyeuristic characteristics of the reader (Mykhalovskiy, 1996; Pryce, 2002). There may be an element of truth to these remarks; however, Ellis (2004) suggests that a researcher not acknowledging their subjectivity could be considered more self-indulgent than one attempting to provide insight into the process. Mykhalovskiy (1996: 140) argues that by viewing autobiographic narrative as self-indulgent it ‘collapses the text’s author and reader into one’. Criticism of narrative being about the self-engrossed writer rather than the relationship between writer and reader is incongruent with other work on narrative which maintains that the reader, in fact, rewrites the story as they read (Burnard, 1995; Mykhalovskiy, 1996; Bochner, 2001; Frank, 2000; Holloway & Freshwater, 2007). I believe that in presenting my findings within the context of my lived experience and my personal story I link the context of my research with the sociological environment in which I function (Mykhalovskiy, 1996; Bochner, 2001; Dressel & Langreiter, 2003).

Being a nurse and an educator, I feel it is not humanly possible to disregard any identification I have with the nursing students participating in my study. McCorkel & Myers (2003) argue that the researcher’s position affects all aspects of the research process. Therefore, if I profess a student-centred approach to my teaching and wish to remain ‘true’ to the participants in my study, I am ethically obliged to acknowledge my identification with the participants and provide transparency of my thought processes and decision-making. In other words, by representing their experiences within the context of my life history I am allowing the reader to understand – to some degree – how and why I am interpreting the stories entrusted to me. I feel that in this way I acknowledge the individuals who were prepared to work so closely with me (McCormack, 2001).

I have attempted not to be self-opinionated or too self-critical, but to present influences and interactions as I’ve understood them at the time. But, whatever the reader’s view on the self-indulgence of autobiographical research, I hope my narrative will stimulate reflection.

I’ve presented my thesis as an aspect of the methodology in its own right. It has been organic in its evolution and development. It is a representation of the research process at a meta-level, filled with contradictions and contrasts; different fonts, colours, art and theoretical frameworks, practical research and reflection – it’s all part of the same story and it represents the complexity and messiness of research as I experienced it.

The contradiction of trying to interface the freedom of art in which we try to deconstruct reality using a medium other than words, and the rigidity of theoretical models in which we attempt to contain and construct reality is, as I see it, the dilemma the students face in practice ... integrating their own philosophy and art of caring with the rigidity of nursing models and ward cultures. In fact, it is the dilemma we all face in striving for ideals and yet adapting to imposed (organisational) norms. This process demands creativity and integrity, and the will and courage to survive.

At another level my inner contradictions have been polarised and I provide myself with an alter-ego called Peter – in doing this I have attempted to capture my inner struggle and turmoil and, at times, the dark, unseen side of professional life. In my story, past, present and future merge, as do the students' stories and mine and ... the story is incomplete. The story represents my knowledge and insight as it is now. My development is ongoing and things I don't know now, I can't discuss, but I believe I shall look back on this work in the future and understand more fully.

To provide structure I've chosen to divide my thesis into 10 sections. This is, to a degree, an artificial division. The first three sections deal with background information and the theoretical frameworks and section 4 is about methodology. The next five sections are case studies of the individual students and the final section (section 10) discusses the value of the study.

The study is contextualised by my story, which can be seen as a sixth case study and, as such, runs through the thesis from beginning to end in the form of reflections in serif font (Times Roman), the lines set full justified, as in this preface. The rest of the text is presented in standard sans-serif font (Verdana), the lines set left justified only.

The case studies are contextualised by drawings done by the students in which colours play an important role. Each case study is presented in what I see to be the student's colour. The final section is in blue as, to me, it symbolises catharsis and healing.

I hope that my work resonates at both a professional and a personal level and I challenge you to engage with it and reflect on what your story means to you.

## **Acknowledgements**

I wish to acknowledge and express my gratitude to those individuals who have been directly involved in my journey, a journey that has been both life-changing and transformational.

- Annemieke, Isa, Linda, Marijke and Olga for your participation and reflections – without you this journey would never have been possible.
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Looking back, I am indebted to many people who have influenced me throughout my personal and professional life. There are too many to acknowledge personally in the context of this document, unfortunately, but I should like to dedicate this to Mom, Dad, Mother (Aunty Vi), Aunty Bess and Uncle Reg. Without you ...

Thank you.



### **Author's declaration**

Some of the work on confluent education in Section 3 has been taken and adapted from my Master's thesis: *Is experiential learning the link between theory and practice?* (Esterhuizen, 1997).

## **Glossary**

**HBO-V:** Hoge Beroepsopleiding – verpleging – Higher nursing education, an equivalent level to a BSc. degree

**Level 4:** A middle-level education qualification which allows full nursing registration with the national body

**Level 5:** A higher-level education qualification which allows full nursing registration with the national body

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## **SECTION ONE**



## **Introduction**

As a reader you will immediately be drawn into my life-story as it provides the context through which I interpret and discuss the stories related to me by the students who agreed to be part of my study. Their case studies are, therefore, embedded in my story and highlight issues related to my being a nurse, an educator and a researcher. This was not how I originally planned and started my research four years ago – I had planned to plot (objectively) what the students' experiences were. At this stage I can safely say that the process of my doctoral study has been one characterised by personal discovery and reflection.

I hope to capture this process – without compromising the role of my participants – by presenting my study at two parallel levels. One level deals with the case studies of five students whom I followed for the duration of their four-year undergraduate programme, and the other with my personal experience as an educator contextualised by my socialisation into the nursing profession and later into academia. My thesis does not always follow a conventional format as my methodological approaches developed during the course of the study and I have thought long and hard about how I could best present the complexity and messiness of my research. My assumption is that many strands, ideas and emotions will emerge and I find this realisation, in fact, quite overwhelming. My decision is, therefore, to keep my presentation as simple as possible and tell the story in my own terms. I have also come to accept that this product is not final, but rather an introduction to infinite avenues of discussion and further research. I have had to make decisions about what to include and how my choice impacts on my participants' stories ... and what it means in the context of my own story. I have also needed to reach a point at which I decide to end this narrative in order to start on the next.

I use an ethno-methodological approach to discuss the case studies of my five participants through which I attempt to identify and explain how I perceive that the students make sense of their environment and deal with the situations and challenges they encounter. I use a reflexive, auto-ethnographic approach to address my personal experience in which I present myself in the form of a sixth case study which includes reflections that influence my decision-making and attitude to nursing and education. It is my case study which provides the thread that takes the reader through my thesis. My referring to accepted terms to categorise the research methods I use does not mean that I adhere to these approaches in their pure forms, but rather that I apply and adapt them as the complexity of my research unfolds. I have, however, attempted to provide transparency and clarity throughout the research process, which will provide the reader with validity and reliability (Holloway & Freshwater, 2007).

My thesis is my story – told as accurately and truthfully as I can – about my background and professional education and how they have impacted on my work as a nurse and still impact on my work as an educator and a researcher.

Holloway & Freshwater (2007) discuss the concept of narrative in terms of story, plot and narrative. This seems a good place to start. The plot – ‘the circumstance which brings the character to life’ (Holloway & Freshwater, 2007: 10) – will be the stories of their progression through the nursing programme of those five students who agreed to be participants in my study and my role as a researcher in which I attempt to provide the reader with transparency regarding the research process. My ‘emplotment’, however, is the impact the students’ stories have on me and how I relate to them within the context of my life and experience.

In my narrative, I challenge the reader to reflect on their own experiences and appreciate the personal journey we all make when we attempt to provide person-centred, holistic care and education ... so easily said ...

### **Background narrative**

I wrote:

Little has been published on professional and occupational socialisation to nursing within a Dutch context. Judging from British and North American literature it would appear that nursing students, at times, socialise by adapting to the ward cultures where they obtain their practical experience. In many instances this is described as being a negative experience and students appear to be pressurised into adapting to a ward culture due to the perceived threat of official and unofficial ward assessments by their mentors. There are cultural differences between The Netherlands and Anglo-Saxon countries regarding issues of authority, formality and nursing tradition, as is there a difference in the study route chosen by the Dutch student nurses taking part in this research. It is, therefore, worth investigating whether Dutch nursing students become and remain alienated from their personal, internalised norms and values as described in the literature, or whether they are able to maintain their initial approach throughout their professional education.

When setting the parameters for this study it is important to consider issues affecting the student’s learning in the clinical setting. Issues such



as workplace and work-based learning, the student as an adult learner and nursing sociality, but general socialisation and culturalisation issues also need to be considered to provide a context for the student's journey from neophyte to registered nurse.

This summary above, which I composed for my MPhil/PhD proposal is, to a large degree, a progression on my Master's research in which I explored issues influencing the way registered nurses use information obtained during formal schooling.

The Dutch nurses who agreed to participate in my Master's research all reported having had issues relating to peer pressure that caused them either to implement or not to implement the theory they'd learned (Esterhuizen, 1997). I figured that it would be important for me to look at primary socialisation into the nursing profession if I were to come to grips with understanding why nurses are so traditional in their outlook and so difficult to shift in their ideas (Walsh & Ford, 1989; Ford & Walsh, 1994). Besides, Melia's (1987) work that I studied as part of my Master's degree is clear about the oppression apparently rife in nursing and nursing education.

### **The first 'real' supervision meeting**

It's 9 am on Wednesday, 26 November 2003 and I'm meeting with all three of my supervisors to discuss my PhD research proposal. I'm excited and feel very confident about the work I'm planning to do – investigating the socialisation process of Dutch student nurses. It is an area I still feel very involved with, having worked with students as a clinical educator in The Netherlands for 10 years. It's also an topic that I think I understand as it is loosely based on my Master's research on how registered nurses apply knowledge learned during a course – this research project threw up all manner of issues related to socialisation and peer pressure, hence my choice to take the research forward using undergraduate students. I am interested in seeing whether or when the socialisation process starts as a student and, perhaps, see where the link lies regarding student adaptation to their environment. Actually, if the truth be known, I already pride myself on knowing exactly where the links, challenges and problems lie – it's just going to be a matter of underpinning how it works.

Added to my confidence of knowing precisely where my doctoral research is going and how it's going to unfold, is my new lease on life, having started as a research practitioner at the university almost two months previously. A total change in career direction and a move to another country in a man's 50th year is very flattering. And then the opportunity



to live in a seaside resort in student-like digs is cause for euphoria in anyone's language. So I am ready for my meeting with my supervisors.

The supervision meeting gets underway and we discuss my approach, the methodology and all the usual things I've thought through – just a case of filling in the blanks. Out of the blue, one supervisor looks at me quizzically and asks, with perhaps a little too much of a knowing glance around the room: 'Can you explain to me how your research fits with your own socialisation?' I'm vaguely aware of smiles playing around corners of mouths in the room, but somehow I'm fixated by my supervisor who posed the question – she seems larger than life and threatens to fill the room. I'm aware that I'm swallowing and playing for time – 'What is this woman on about?' It's clear, isn't it? I'm researching the students' socialisation, not mine.' I'm asked to reflect on the question as I continue the study ... someone else in the room is talking about a PhD being transformational. I'm sure it will be, if I know what they mean by it. I'm nodding knowingly and agreeing to all manner of things I'm not really understanding – it'll come with time.

I leave the room after the meeting and return to my office desk to summarise the meeting. I write in the summary as point number 4:

A more 'open' approach to the project is necessary in order to be less directive in terms of the objectives. Also, by setting fixed objectives it detracts from the inquiring nature of the research project.

Suggestions:

- Rethink the title as this is challenged by the enquiring nature of the project (the title contains assumptions from the literature and therefore directs the research, while the research should be open and enquiring).
- Reformulate the aims and objectives.
- Reflect on my personal history, including position, perspective and work experience, and document the information in order to provide a context for my own research process.
- Rethink the chosen methodology and use a more open approach – perhaps use a form of grounded theory approached from an ethnographic perspective.

### **My 'own' socialisation?**

A quantum leap forward in time to July 2006 – almost three years of reflection and supervision, writing and transfer viva and only now am I starting to get to grips with what

was meant by asking me to explore who I was in relation to 'my' students and looking back on the route I've travelled ... yes, it has been quite transformational ... I feel quite different now ... but probably more to the point, I'm aware that I'm in 'the process'. Being aware of the open-ended nature of my research and being comfortable with allowing myself to be where I am within the process is, in itself, a new experience.

Along the three-year route, the supervisor's question 'Can you explain to me how your research fits with your own socialisation?' still rings in my ears at least once a day and I've tried to piece my own socialisation together, yet somehow true understanding still seems to elude me. In contrast to the often negative publications implying that nurses and nursing students are bullied and coerced into submitting to some professional mould, I can't recall any instances during my nursing education or experience which brought me to my knees. In fact, I'd say that I had a pretty uneventful student life and took most everything in my stride ... perhaps that was because I was a bit older and the opposite sex to my fellow-students.

My 22nd birthday present to myself was that I was sitting in a lecture theatre adjacent to a large teaching hospital in Cape Town with a 40-year-old Anglican minister who was wanting to get 'nearer to the people again' and 99 young women – we were all starting with the first day of theory as part of the in-service programme to become General Nurses. I remember asking myself quite how I'd got myself into a situation like this – in fact, my mother had articulated it perfectly by asking me whether I couldn't 'find anything better to do' than to take up nursing. On the other hand, I am instantly fascinated by what we were being told and studying the facts and figures doesn't present a problem at all.

I suppose one person who changed my outlook on nursing dramatically was Miss Parsons – an attractive woman of around 30 who announced profoundly one day: 'Girls, once a nurse and you're always a nurse' – I'd never thought of it quite in those terms and I felt admitted to an inner circle whose knowledge and skills could mean life or death to another. I was also quite unperturbed by being referred to as one of 'the girls' – she'd excused herself to the two men present and sublimely continued to refer to us all as 'girls'. I suppose, in retrospect, I could see this as being part of a depersonalisation and, in the case of the other male colleague and me, a de-sexing. Although I don't recall feeling alienated by this, it did make me feel different – one of them – a member of an inner circle who understood some of the mysteries of life and death. It admitted me to an elitist group of knowledge-holders – different from the work I'd done before in the bank, men's fashion and administration. The idea of being part of a fraternity is still strong to this day and although I've not been directly involved in bedside nursing for some 13



years already, I don't feel any less a nurse now than I did as a first-year student nurse in 1976.

As I write this, I'm aware that I'm not comfortable discussing the issue of my sexuality in such a public arena even though I consider myself to be open about who I am and my longstanding relationship. I'm also aware of consciously censoring how I write about my feelings of being acknowledged when being referred to as one of the girls. At this stage, I'd come out of the closet with regard to my sexuality and had wrested my way clear of the dramas of acceptance my mother had with my sexuality (no one else seemed to have an issue with it). I'm conscious that my feelings of being admitted to the inner circle of nursing may well have quite a lot to do with this, apparently unconditional, acceptance into a feminine world – a place I'd felt part of for many years, but had always seemed to be on the periphery of. Now, as an adult, I was being admitted on the basis of my own merit and of my own doing. It was not a surrogate admission based on the needs of another.

Soon I was alone with the 99 'other girls' as my priestly peer dropped out of the programme shortly after starting.

I experienced my first (and only) cardiac arrest during my first placement in practice. A woman, due for discharge the next day, had asked for a bedpan and took too long before asking for it to be removed. With no answer to my request as to whether I could enter, I did and found that she'd arrested – resuscitation didn't work, so, first year and first placement, I was expected to lay her out. Gulp. All went well, except for the sigh of escaping air from her lungs as I turned her (never to be forgotten) and the fact that I couldn't remove her wedding ring. My distress must have been very visible when the sister in charge told me to get a move on and 'break her finger if you have to'. Needless to say, I didn't, but used lots of soap and water until finger and ring parted company. This is an interesting point of reflection for me as I don't recall having discussed death and respect for the dead and dying, but somehow the pressure of authority didn't even begin to weigh in against the care I felt I needed to provide for the person who had just passed on. Breaking her finger to remove her wedding ring was simply not an option to be considered ...

Also during my first placement in practice I had a run-in with a staff nurse.<sup>1</sup> I was on night duty and had worked a couple of nights with a sister (registered nurse) – things

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<sup>1</sup> In South Africa at the time, a staff nurse was a qualification after a two-year training programme. Although this qualification provided a stepping stone to enter the programme to become a registered nurse, a first-year student on a registered nurse programme was (theoretically) more senior than the qualified staff nurse.

were quite informal and everyone organised their work, negotiated breaks and generally it was very pleasant. Then the night sister had nights off and was replaced by the staff nurse in question and things changed: no more autonomy and we had to be solely responsible to her.

A few nights into working together and I'd been humouring her and playing along, when she commanded me around midnight to go off and close off the fluid charts, finishing with '... and no slapdash job.' I was silent and did what I had been told to do. An hour later I suggested that I have my break, for which impudence I was reminded that she was in charge and that I would go on my break when she saw fit. At that point I, again silent, retreated into one of the side wards and sat in the darkness amid the sleeping patients – fuming and close to tears of frustration. I remember clearly that the patients' rhythmical breathing calmed me and I started feeling resolute. I couldn't have been there long when the nurse aide came to tell me that I now could have my break. Very calmly I popped my head into the office in passing and said I was off the ward for my break and headed straight for the matron on duty. I remember her being probably in her fifties and quite motherly. I told her what had happened and calmly announced that I refused to work with this staff nurse any longer. (I smile as I write this. I had never heard of whistle-blowing or anything else and now, 30 years later, I can only imagine what the night matron must have thought.) She listened and suggested that I understand that the staff nurse may have problems with control and authority, etc., to which I replied, 'that's all well and good, but I have come into nursing to do a good job and not play games with the frustrations of others' (again I smile at my youthful brute cheek).

During her break, the staff nurse was summoned to the matron and that was the last night I ever worked with her. I remember spending most of the rest of the night in the dark and quiet rooms with the patients – calm and content, and quite a bit smug (which wasn't very charitable.).

These two situations were quite formative for me in my professional development – Miss Parson's pride in her profession and spontaneity in dealing with a horde of first-year students, on the one hand, and the staff nurse's apparent inability to abrogate responsibility and allow others develop theirs, on the other. Also, there was the matter of the night matron's decision to act by swapping staff between wards based on the story of a first-year male student nurse in his first placement.

This inter-collegial behaviour and control is discussed in the literature (Randle, 2003; Farrell, 2001; Freshwater, 2000b) and on reflection I would have perceived the situation

very differently had I not felt supported by the night matron. At this stage the situation with the staff nurse flags up two issues I'm not fully able to address: was there anything in my behaviour towards the staff nurse that perhaps caused her to react in such an authoritarian manner? And why did the night matron decide to take the drastic action of shifting staff between wards during night duty in order to meet my needs? Naturally I have theories about the staff nurse's behaviour being known and my story being the last straw breaking the proverbial camel's back; but I do find it mystifying how these situations all occurred within the first six months of my training, providing me with a very positive view of the nursing profession.

I think that my resolute reaction to the situation with the staff nurse has a direct link with my experiences at school and in my military service – between 10 and 20 I was bullied on a daily basis – this was always related to my perceived effeminacy and softness. I may have identified the staff nurse's aggressive behaviour towards me as bullying based on my sexual orientation, causing me to respond as resolutely as I did. I don't think I wanted any chink in the near-perfect world that was now beginning to accept me as an individual.

A patient-related situation which made quite an impression on me in that first year of training was when I was on a theatre placement. I remember there being quite a stir one day as one of the private doctors was bringing in a lady-friend after the other lists had been completed ... for an abortion – except that the woman was well into her pregnancy and so labour was induced. The theatre was manned by minimal staff late one afternoon and I was the only student present, together with a sister and the theatre matron.

The result was a foetus that moved, but which would not have been viable. This tiny life was then placed in a steel receptor, covered with a paper towel and left to die on the windowsill in the sluice room. We were banned from entering the sluice and certainly from touching the foetus. Needless to say, I did enter the sluice room and I touched the foetus – I like to think it was because I wanted to comfort and nurture, but I must admit there was also a degree of morbid fascination.

I remember being horrified at what had happened and really disliking the doctor after that, also feeling very relieved that I didn't need to nurse the mother as I doubt whether I'd have been able to be unbiased. I also remember the non-communication about the incident. A few hours later and it were as though it had never happened. One thing that lingers in my mind is that no one ever spoke about the situation afterwards – ever. There was no debriefing and no stipulation that it was all to be very hushed, but somehow this was communicated. Although I can't imagine that everyone simply carried on after the



event as though it had never occurred, I know I did. I was, after all, now part of the inner circle.

Life just carried on and it is only now and then that I think about this event and reflect more deeply on what actually took place.

Reflecting on situations 30 years later is, naturally, larded with hindsight. But somewhere in the situation there must have been a warning present that this was not the time or the place to be squeamish about this type of thing. I must have thought that this was part of what being in the inner circle was all about – protecting colleagues and not making life difficult for them.

I don't think, at the time, I was even too worried about the ethical discussion about terminating life – even an advanced stage of life. I think what I found difficult, and at some deep level still do, is the fact that the foetus was left to die inhumanely. It could have had some love, for want of a better word. It was a fact that the mother had already decided that she didn't want the child and had found a doctor to help her; I can't be judgemental about the circumstances and it's not my place as I didn't – and still don't – know anything about the situation. But I feel strongly that within any patient-related situation there needs to be an essence of care and love; otherwise I can't talk about nursing as I understand it to be (Widdershoven, 1999; Nåden & Eriksson, 2002; Sticklely & Freshwater, 2002; Nåden & Eriksson, 2004).

In terms of socialisation, the episode of this baby's brief life taught me that certain things happen within the inner circle that one simply doesn't talk about – taboos? Or is it an unspoken fear of repercussion and consequence? In this case the hospital was dependent on private doctors using the facilities, the theatre matron and staff needed to have a good relationship with the doctors and I can even possibly think that I was chosen to stay on to help: I was older than the other students, a male (so theoretically I possibly wouldn't have the same emotional connection with abortion) and a first-year student. When looking at my status and position from this perspective, it does have a certain tinge of power and exploitation. I can see this now as being a not too subtle form of coercion into a position of silence and, 30 years later, it would be the subject for a rather extensive clinical supervision or critical incident analysis – something unheard of in a middle-sized White South African hospital at the end of the 1970s.

At the end of my first year I transferred from Cape Town to Johannesburg due to my mother's ill-health and started my second year at 7 am on New Year's Day in 1977 on a surgical ward. The atmosphere on the ward was scary – and new to me. The hospital in

Johannesburg was far larger and busier than where I'd spent my first year of training in Cape Town. What was it about this ward that was scary? A Hattie Jacques-type sister was in charge – large and robust, with lace-up shoes, who barked rather than spoke and who knew exactly what was going on with everyone, all the time. She did, however, provide structure and support and always seemed to be there if you needed her – not that she suffered fools gladly. But it was this very person who, two years later, at the end of my training, when I was placed on her ward for a second time, announced to all the patients in the Nightingale ward that I had passed my State Examinations; removed her epaulettes from her shoulders and pinned them on to mine for the day and led the patients in applause as I marched down the length of the ward (blushing profusely, I may add) to acknowledge my achievement and seal my final entry into the inner, professional, circle. I remember that moment as being warm and accepting.

I am curious about my thoughts of being admitted to a closed circle and was intrigued when I read *Discipline and punish* (Foucault, 1977). He discusses the power possessed by magistrates and clergy, and their secret committees, when sentencing criminals in the 17th and 18th centuries – referred to in this context as 'patients'. The accused in this situation knew nothing about the charges levelled at them, or the process of decision-making which led the 'experts' to their decisions. This has caused me to pause and contemplate the secrecy and mysticism society seems to award (para)medical disciplines to the present day – although this is changing. As was the case four centuries ago, for a magistrate to err in passing sentence was tantamount to public atonement and being responsible to a higher power. Could this be a comparable situation to the responsibility accorded the medical profession up until today? They speak their own language and although the general public are continuously provided with information – it remains a daunting experience to challenge someone in this position. The public outcry when mistakes are made by medical staff seems comparable to the principles of infallibility held high centuries ago. Nursing has also a mystical status in history – the wise woman or apothecary was considered to have supernatural powers and was revered, but in some cases was feared and martyred by those in power for her or his knowledge. It is interesting for me to reflect that this secretive and sometimes victimised world is one that I was keen to join.

The second and third years of my training seemed to pass uneventfully. There were the usual gripes about duty rosters and night duty, but no more than for any other student.

There were the emotions associated with laying out a 'favourite' patient who, to me, had lived a full and varied life – including having attended the Queen's Garden Party at Buckingham Palace – and who had now died alone and friendless. All his worldly



possessions were contained in a single plastic bag and they included the pile of yellowed photographs which he'd proudly shown me in the knowledge that his only child – a son – was out there somewhere and wanted nothing to do with his father. I was honoured to have to prepare him for his final journey and remember crying as I zipped him into the regulation plastic shroud and placed his bag of belongings on his bed next to him. Thinking of the situation now, it had some similarity to the baby left to die on the windowsill. Can we, as nurses, really be with another human being at that final time of passing? Or is it perhaps the fear of our own mortality that drives us to make sense of something we deeply abhor? Were my tears the realisation that, whatever we may think and whatever feelings we may fantasise, we are ultimately alone? I don't remember there being any talk of this situation at the time or afterwards – no debriefing and no reflections, just washing my face and getting ready to face the rest of the ward again. Colleagues may well have seen that I'd been upset, but nothing was said. At the time, and from my current perspective, it seemed alright – my privacy was respected and I never asked to speak to anyone. It was my personal story that I shared with friends and family, but no one really seemed to understand, so the subject was soon dropped and life continued. I did, some years later, out of the blue, attempt a little poem which, again, in retrospect, seems to mirror what I was feeling at the time:

*I Alone  
Alone.  
Not quite.  
People all 'round –  
Moving, seething,  
involving, meeting.  
Try as I might  
Not I.*

*Alone.  
From the start.  
People were there  
naturally, yes.  
Emotion was there  
greater not less.  
Try as I might  
Not I.*

*Alone.  
No one to turn to.  
People called friends –  
backwards and forwards  
To each his own ends.  
Nowhere to go.  
Try as I might  
Not I.*



*Alone.  
On the beach  
at the end of the day  
waves seem to reach.  
Nowhere to go.  
Try as I might  
Not I.*

*Alone.  
To the end.  
People still 'round –  
moving, seething,  
involving, meeting.  
No one to care.  
Try as I might  
Not I.*

Then there was the time, as a third-year student, when I came on night duty in the Accident & Emergency Unit at 7 pm. I was asked to go to the surgical crash room to special a patient who was waiting to go to theatre – the young man had attempted suicide by a trying to blow his brains out using a double-bore shotgun ... only it'd gone differently to the way he'd planned it and he'd succeeded in blowing the front of his face off instead. It wasn't a pleasant site and my role was to sit and talk to the patient, make sure that he remained conscious and could breathe – all the while looking at a bloody mass that was once his face, punctuated only by an endotracheal tube through which he breathed. With the initial shock over, it's amazing the kinds of monologues you're able to produce requiring hand squeezes from the other person. Looking back, I can't imagine how the scene must have appeared – a very bloody and traumatised patient and a student sitting chattering away, measuring his blood pressure and holding his hand as though it were the most normal thing on earth.

After about an hour I was relieved from my post as things had become very busy in the A&E and a second-year student nurse was sent from one of the wards to special my patient. I could see the (what I interpreted to be) shock and disgust on her face as she walked into the crash room, but I remained calmly talking to the patient until she'd composed herself, introduced her to the patient and left her to get on with where I'd left off. I distinctly remember popping my head round the door at regular intervals to check how she was doing and let the patient know that I was still around. Thinking about this now, I don't recall ever having been told to do this, or having seen anyone else act in this way. It just felt that it was the right thing to do. I never spoke to the student about the situation when the patient went off to theatre, nor did I speak to her again – in fact, I can't even remember seeing her again after that situation (but then senior and junior students

didn't really fraternise, now did they? It just wasn't done.) I don't recall feeling the need to talk to her about the situation – it was all just part of one's work, one got on and did what one had to do.

I think by being a male and a few years older than the average student nurses I was given responsibility and probably left to my own devices more than my peers. This may explain why I can't recall situations where I felt pressurised into adapting to fit into the culture. I generally felt part of the ward teams quite quickly and I loved my work – especially night duty, when the nurse/patient relationship is intimate and cloaked in darkness. I don't think it had to do with power on my part, but more the feeling of being able to watch over those in my care, to be there when they were most afraid or distressed – this aspect of being in the inner circle was almost sacred, a calling – I was in the right place.

I interpreted it as a definite acknowledgement of my being in the right place and defiant moment of triumph directed at my mother when I was awarded the Banfield Prize at the annual graduation:

*The Banfield Prize – 1978*

*This is the highest honour which this Hospital bestows upon one of its diploma students of nursing. The award is conferred upon the student nurse who has maintained the highest standard in all aspects of his profession and is not based upon the purely academic achievements of the student.*

*Philip Esterhuizen*

... and that after she had asked me whether I had 'nothing better to do' than to go into nursing.

**My socialisation in relation to my background?**

In remaining true to my philosophy in which different aspects go to make our holistic being, I can't ignore my 'being' prior to entering the nursing profession. I am not just a nurse or a researcher, but have been formed through my personal and unique history, as has everyone else. My socialisation, therefore, starts way back and in writing the story of



my professional socialisation, I've become aware that three themes seem predominant. The first: authority and my response to it. The second: life, death and dying. And the third: acknowledgement of who I am and my choice of career.

As the youngest of three sons by 10 years, I was probably moulded quite significantly by my dominant mother and psychologically (if not physically) absent father. From my eleventh year I was an only child at home and saw my brothers only when they visited, which meant that I had the full focus of my mother. In hindsight, I would call the family relationship dysfunctional and my mother's role manipulative, rather than dominant. The symbiosis of this mother/child relationship (Miller, 1994) resulted in my becoming overly sensitive to her needs and adapting to prevent confrontation or distress on her part. Failure to play this role would mean overwhelming feelings of guilt on my part and resultant overcompensation to make things right (Beattie, 1989). This mother/child relationship must have had an impact on my sensitivity to (feminine) authority and, to my mind, my understanding of what it means to be unemancipated and disempowered. I am aware of ambivalent feelings with regard to being protected by my mother – on the one hand, I was often closeted away from physical dangers (or rather what my mother perceived as being physical dangers), yet, on the other hand, being overly exposed to her personal disappointments as a woman.

Rereading this, it's interesting for me to become aware that my only experience of protection in the face of what possibly was real danger was not by my mother. Growing up in Zimbabwe in the 1950s and 60s – then Southern Rhodesia – I was/we were exposed to racial tensions and violence. The time when the Kenyan Mau-Mau form of urban-terrorism was trickling into our society, Molotov Cocktail attacks – 'petrol bombs', as we called them – were rife, helicopters dropped pamphlets providing emergency information and all men above the age of 16 patrolled at night, keeping the white enclaves safe for the women and children ... today Mother was away at work as a milliner in the City of Bulawayo and I was cared for by the black garden boy – Saze. Saze and I did a lot together – ate, showered and played. But this day Saze was alert and anxious – all the curtains were drawn as we heard chanting coming down the road. A group of African men brandishing machetes, clubs and shields. I remember Saze clutching me to his breast and sliding us under my brother's bed. I remember his smell, his pounding heart and his sweat. As a child of seven or eight, I knew to be quiet. We lay there until all was quiet, but the rest of the day we spent indoors, playing very quiet games. This was great – the helicopters had dropped messages to say that we weren't allowed to go to school, so this kind of game with Saze was infinitely more exciting.



Surely this must be unconditional love and care? Surely Saze must have faced the dilemma of divided loyalties? But, as a child, this love was reciprocal and basic – I pined for him when we left Rhodesia for South Africa and left him alone to face a very uncertain future.

Articulating these thoughts about myself in a very public arena, I'm aware of feeling guilty and vulnerable – strong feelings that are threatening to silence me yet again. It's interesting to me that I feel that I'm about to be silenced again – perhaps, during this process, I'll recall when I felt silenced for the first time. I need to acknowledge this inner voice, give it a name and make it visible as it will, I'm sure, be back. So I will name it Peter – a name that I've often mistakenly been called throughout my life. Peter's voice is not the voice of theory, but one that challenges my decisions and sometimes causes me to doubt my capabilities; in some ways, a voice that allows me to reflect and challenges me to strive for something more, rather than simply accepting mediocrity. Peter's voice is not negative, neither do I see it as being some pathological, 'invisible friend'; I use it in the context of my thesis as a way for me to clarify and personify dialogue with myself.

It is now interesting for me to talk of being 'silenced again', considering I literally only found my voice at the age of 17 after a five-year period of self-imposed silence.

I was in the end-of-year musical at primary school. Having one of the leading roles as Gypsy Gay's father at the time my voice was breaking was not the most appropriate combination. Neither was it, in hindsight, sympathetic on the part of my teachers to put me in that position. The net result was that I single-handedly turned what should have been a production filled with pathos, culminating in a happy end, into a side-splitting comedy from my first entrance. This is was quite a remarkable achievement for a 12-year-old.

From that moment on I didn't speak and, if I did, it would be to produce a hoarse whisper. Oral exams at school were purgatory and were usually whispered during breaks and always at the teacher's desk so that they could hear me. Fellow-scholars were less sympathetic.

The intervening five years were spent having weekly nose washes and writing notes for shop assistants whenever I needed to communicate. My communication at home was whispered and no one seemed particularly perturbed that nothing seemed to be improving. It was a time of withdrawal and the creation of my own safe world of books and dreaming and fantasy.

At 17 an aunt suggested I visit a retired ear, nose and throat specialist, who listened to me for a few minutes and sent me on my way with voice exercises and copious doses of Librium. The combination seemed to help and within a few weeks my voice had settled and I could communicate normally.

It seems odd that my history should lead me to the nursing profession, where communication is so very central, and later into teaching and conference presentations, where I need to speak publicly. I am, even now, aware of a feeling of achievement whenever I've presented or taught.

Peter is questioning whether Philip's motivation to leave South Africa to travel for a year, but ultimately choosing to stay in The Netherlands, was purely based on a travel bug, or whether this was his way of escaping from what may have been a deeply unhappy life – one of restriction and silence: personal, political and professional.

Could this also explain Philip's impatience with those who refuse to recognise or deal with issues making them unhappy? Could this process have taught and substantiated that the idea of being alone is not that far removed from reality and that few people are, or perhaps can be, interested in the welfare of another? This surely can't be right ... could this have been my underlying motivation to enter nursing? Was it, based on Saze's role modelling of the essence of caring, Philip's desire to provide anonymous and unconditional love for another human being? Is this the origin of his passion to understand the concept of care, ethics and morals? Was the reason for settling in The Netherlands a way of distancing, of objectifying? To choose a country foreign in language and culture, but liberal and tolerant to provide a mirror image of the past? Again the concept of silence is raised – not being able to communicate in a foreign language and being in a situation in which I had no history – I re-created myself. I have created my own power. I contact those from the past on my terms – the tables are turned: personally, politically and professionally.

Peter wants to know whether Philip entered nursing because he wanted to have power over others – the sick are vulnerable, after all. Is this the motivation for being a teacher? Is the buzz of presenting at conferences a show of power and authority?

Philip feels angry, but not defensive. Could I have coned all those in authority in order to win the Banfield Prize and earn, in all humility, (international) respect from peers? Is my passion to share concepts of care and humanity with students and colleagues, really just power and control? No, I don't believe it is and I don't want to be drawn into



negativity. I do, however, want to reflect on how I work as an educator and how I am influenced in my role by who I am.

The issue of my personal socialisation is my first cathartic experience.

From the safety of this new and re-created being I entitle my thesis: **The journey from neophyte to registered nurse – a Dutch experience.** I am, however, now more convinced that it will be more about 'the journey from then until now – my experience'.

## **SECTION TWO**

### **Working in The Netherlands**

It has been beneficial to nurse most of my working life in different health-care settings in The Netherlands before working as a clinical educator in a general hospital. General, theatre, community and terminal care in the home situation have provided me with a broad experience that I'm able to draw on in different teaching and supervision situations.

My clinical educator role allowed me to develop practice-based curricula based on the principles of reflective practice and allowed me to work closely with students in the clinical setting. I would like to use this as a point of departure to provide background understanding of how I came to focus my research on the socialisation of Dutch students.

In The Netherlands, two four-year routes lead to a nursing BSc – one being the so-called full-time course (HBOV) and the other an Institution-based course (HBOV-duaal). In the HBOV the student studies full time, with clinical placements of 10 weeks per year.

My work as a clinical educator primarily involved students undertaking the institutionally based course and so this study focuses on a number of students in a cohort of the HBOV-duaal variation.

In the hospital in which this study is was undertaken, the HBOV-duaal route was as follows: the student, having completed and financed their first year of study full-time, experiences a fragmented but total of two months' placement in a clinical setting, is then employed by the institution. All further study is paid for by the institution and the student is in practice for three days per week. Two days per week are spent on study activities.

After the first year, students spend one day every second week receiving institution-based tuition using reflective techniques and interactive learning with a clinical educator. The students have one day set aside for self-study in the same week. The two study days of the other week are college-based. The students are continually exposed to practice – 20–30 weeks in one department (see appendix 1).

The HBOV-duaal programme is based strongly on the concept of workplace learning by means of clinical placements being a way of achieving academic credits. The Nursing and Midwifery Council standards (2004), in accordance with the European Commission Directives on Nursing Education, suggest a 50/50 division between theory and clinical practice in an attempt to ensure fitness for



practice. This is comparable to the guidelines set out by the Dutch Ministry of Education, Culture and Science<sup>2</sup> (1996).

My assumption is that this lengthy exposure in one department could potentially precipitate role confusion: is the student merely just that or is he or she an employee? In addition, the literature on occupational and professional socialisation within the clinical setting is generally 'negative'. These two aspects of the educational system stimulated my curiosity about how students undertaking this programme developed in their professional role. I saw the student's professional development as being synonymous with their socialisation.

Little has been published on professional and occupational socialisation to nursing within a Dutch context. Judging from British and North American literature, it appears that nursing students, at times, socialise by adapting to the ward cultures where they obtain their practical experience. In many instances this is described as being a negative experience and students appear to be pressurised into adaptation to a ward culture due to the perceived threat of official and unofficial ward assessments by their mentors (Melia, 1987; Spouse, 2000; Spouse, 2001; Spouse, 2003).

I perceive cultural differences between The Netherlands and Anglo-Saxon countries regarding issues of authority, formality and nursing tradition. I also think that the HBOV-duaal study route chosen by the Dutch student nurses taking part in this research could affect their perceptions of adapting to ward culture. I think, therefore, that it is worth investigating how Dutch student nurses develop professionally. When starting this study in 2002, I was curious whether Dutch nursing students become and remain alienated from their personal, internalised norms and values as described in the literature, or whether they are able to maintain their initial approach throughout their professional education.

In my study I set parameters for this study by considering issues affecting the students' learning in the clinical setting. I initially earmarked issues such as workplace and work-based learning, the student as an adult learner and nursing sociality, but I shall also consider general socialisation and culturalisation issues to provide a context for the student's journey from neophyte to registered nurse.

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<sup>2</sup> Ministerie van Onderwijs, Cultuur en Wetenschappen.

In my work as a clinical educator I experienced the impact of student attrition for the first time. Somehow, as a clinician, the student drop-out from undergraduate programmes never really affected me, or had my interest. I started my literature research from this perspective.

### **Attrition, in times of a nursing shortage**

A problem affecting nursing education is the attrition of students prior to the completion of their training. Student attrition has been described as having many and varied causes, and reference is often made to the 'voluntary wastage' of students and the influence of nurse educators in the prevention of this phenomenon (Birch, 1983; Davis, 1983; Lewis, 1983; Searle, 1987; Wilson & Startup, 1991; Spouse, 2000; Spouse, 2001; Glossop, 2002; Last & Fulbrook, 2003).

I found it interesting to read a short, anonymous editorial in the July edition of *Nursing Standard* (2006) in which concern is raised at the average percentage of 25% of students leaving their courses. This is not a new or alarmingly different statistic either nationally or globally.

In The Netherlands, the attrition rate can vary between 15 and 25% per annum (Knol & de Voogd, 1990; van Rooijen, 1990), although this figure has also been quoted as varying between 25 and 40% per annum (van den Bogert, 1993). In the United States, the problem of student nurse attrition is also recognised as an area of concern to educators (Smith, 1990). This was also the case in South Africa, when in 1979 it was  $\pm 30\%$  (Searle & Potgieter, 1980). More recent figures place student nurse attrition in the United Kingdom at a 20% level (Glossop, 2002; Last & Fulbrook, 2003). Judging from the literature, it can be assumed, therefore, that attrition is an ongoing problem and one of concern to nursing on an international scale. In the past decades this problem has been magnified due to the decreasing number of students entering initial nursing courses (Last & Fulbrook, 2003). There is often discussion regarding the definition of attrition, which can vary in meaning from students who leave the course entirely to those who transfer to other courses or graduate with a later group. Within the focus of this study, attrition is defined as being the withdrawal of any student from the research cohort for whatever reason.

Melia (1987), in her book *Learning and Working*, discusses the various problems facing student nurses in their development to trained nurse status. She focuses



on their ability to adapt to the situations in question, and survive. There are, however, annually a great number of student nurses who do not manage this transition and who prematurely terminate their training or suffer a degree of burnout early in their nursing careers. This could partly be due to the fact that registered nurses alter or lose their ideals, norms and values regarding their profession during their initial nursing education, or do not recognise the intrinsic motivation of novice nurses and are subsequently unable to provide them with a positive socialisation to registered nurse status (Siegel, 1968; Policinski & Davidhizar, 1985; Lewis, Ford Gadd & O'Conner, 1987; Kleehammer, Hart & Fogel Keck, 1990; Beck & Srivastava, 1991; Stephens, 1992; Lindop, 1993; Tatano Beck, 1993; Wolfe Morrison, 1993; du Toit, 1995; Howkins & Ewens, 1995; Admi, 1997a; Admi, 1997b; Hegge, Melcher & Williams, 1999; Tanner & Raway, 1999; Spouse, 2000; Tinsley & France, 2004).

### **Occupational socialisation and attrition**

A possible link between a 'negative' occupational socialisation and attrition rates among nurses is easily made. It would seem logical to assume that an 'unsuccessful' socialisation could result in attrition. This cannot be assumed automatically as both Glossop (2002) and Last & Fulbrook (2003) provide various reasons underlying the attrition rate which would probably indicate that a combination of factors are responsible. However, Glossop (2002) suggests from her findings that 17% of students withdrew from the course due to a 'wrong career choice' and 22% provided little or no information as to their reasons for leaving. She also suggests that 56% of the students withdrew during the first 18 months of the course. Last & Fulbrook (2003) establish from their Delphi Study that a 94% majority of the students taking part in the study felt that the programme needed more guidance and structure in the initial phase. The findings of Glossop (2002) and Last & Fulbrook (2003) could then indicate that the experiences of nursing students in their first contact with the educational programme and clinical placement areas provide sufficient doubt as to cause them to withdraw from the course.

What, then, is contained in the professional curriculum and initial contact with the practice setting that is causing this attrition rate? Spouse (2000) and Last & Fulbrook (2003) discuss the lack of morale and high degrees of stress among registered nurses in the clinical setting and indicate that students strongly doubted whether they would want to be part of 'such a workforce' in which they would not be able to provide the care they wanted to provide from an ideological point of view. These authors also discuss the students' lack of confidence to

practice nursing and link their self-confidence level to the so-called theory/practice gap. Randle (2003a) also addresses the issue of the lack of self-confidence and self-esteem, but links this to findings regarding bullying in the clinical setting. Farrell (2001) discusses hierarchical power and the issue of horizontal violence. Both Randle (2003a) and Farrell (2001) suggest that victims of bullying or horizontal violence do not speak about their experiences, but prefer to remain anonymous. This could tie in with the findings published by Glossop (2002) in which a large percentage of students left the nursing course due to its being 'a wrong career choice' or without providing additional information.

The idea of clinical placements being responsible for the undermining of the nursing students' motivation is contrary to the idea of the workplace being a powerful learning environment, as discussed by Spouse (2001).

The question may rightly be asked as to why nurses then stay in the profession if the clinical experience is so negative. Many of the authors quoted have focused on the negative influences in their studies rather than on what inspires nurses to remain in practice. However, a number of authors refer to interpersonal and interactive relationships as providing the nurse with a positive and inspirational experience (Widdershoven, 1999; Spouse, 2001; Stickley & Freshwater, 2002). Philpin (1999) discusses the influence on student experience in terms of distance from the medical model and indicates the positive experience of nurses working in 'chronic areas' rather than 'acute areas' - students appear to be provided with opportunities for interacting with patients and are treated as team members, rather than being subservient. This effect of interacting with the chronically ill appears to place 'care' as a core element of working and learning. This is substantiated by Spouse (2000), who describes a situation of attrition with a return, at a later date, by the student to a course in which nursing was presented as an art and a science, rather than from a task-oriented or biomedical approach. However, Randle (2002), within the concept of moral identity and practice, discusses the desensitisation of students to ethical and moral issues within the clinical setting. It would appear that students and nurses adapt or learn to deal with the moral culture of the clinical setting as they progress through their education and careers. The importance of supporting the original ideals of students and registered staff throughout the process of learning and 'becoming professional' is discussed in terms of revisiting and reworking issues over a period of time (Watson, Deary & Lea, 1999; MacIntosh, 2003).



Revisiting my experiences as a student, I read the literature with interest. At the time of training I don't recall perceiving the pressure of adaptation. Perhaps this was because my life history had, in hindsight, been geared to adaptation. Adaptation had been my method of surviving reality. Although I was not conscious of oppression, the literature resonated with me and part of my research into the socialisation of 'my' students was to prove the point of their being oppressed and coerced into adaptation. This assumption was based not purely on who I am, but also on the stories I'd heard from students about how they hadn't dared challenge registered staff for fear of reprisals and how the participants in my Master's study perceived the power of peer pressure. I found this an oddity at the time, as the Dutch culture appeared to me as an outsider to be non-hierarchical and non-authoritarian.

In my reflections during the course of my study and through formal and informal supervisory meetings I became more open to investigating why students stayed in this 'oppressive' culture and questioning my own assumptions as to whether the culture was actually as oppressive as it was made out to be. Reflecting on my own reasons for staying in the nursing profession, my insights provided me with a sense of belonging but, more importantly, my perception of unconditional reciprocity seemed to instil (and fit with) a feeling of being and self which I found I related to work published by Widdershoven (1999), Nåden & Eriksson (2000), Spouse (2001), Nåden & Eriksson (2002), Stickley & Freshwater (2002) and Nåden & Eriksson (2004).

As my focus was on student learning in the workplace, I looked to the literature to clarify the concept. I was aiming to contextualise the learning environment in order to understand the student's educational process more fully.

### **Workplace learning**

One definition of workplace learning from the Glasgow Caledonian University, as referred to by Clarke & Copeland (2003), suggests that outcomes of learning are specific and planned. Learning in the workplace is placed within an 'academic' context and is related to current theory and practice, the outcomes being assessable and concrete:

... is a sub-set of workplace learning. It refers specifically to the achievement of planned learning outcomes derived from the experiences of performing a work role or function ... it is normal practice to complement the experiential learning with directed reading, research or group work to ensure that learning is placed in the context of current



theory or practice ... must be capable of being evidenced and assessed before it can be recognised by the university.

Another definition approved by the University of Northumbria, Newcastle upon Tyne, and used as a working definition by Chalmers, Swallow & Miller (2001) suggests that workplace learning should lead to obtaining academic credits, the object of practical placements for nursing students:

... mechanisms for learning for work, at work and through work where successful assessment leads to academic credit rating, but not, in itself, a named academic award.

However, taking the complexity of the nursing profession and the subtleties of interpersonal relationships into account, learning within the workplace can be viewed in broader terms.

Benner (1984) discusses another type of learning. More in terms of an individual developmental process, but also using the power of the practice setting:

Expertise develops when the clinician tests and refines propositions, hypotheses, and principle-based expectations in actual practice situations.

Kolb (1984: 26) in fact states that:

Learning is best conceived as a process, not in terms of outcomes.

The questions now raised in my mind are that: if nursing education accepts that the practice setting is, indeed, a powerful learning environment, that if learning is not only a process (rather than purely an outcome), but a transformational process, how, then, can the practice setting – according to some authors – be such a negative influence on an individual's development towards self-actualisation within the professional (nursing) role?

### **Adult learners**

I am not clear in my mind about how the practice setting can be perceived as being so destructive when the discussion relates to *adult* student nurses who are learning? – *adults* who have made an informed decision to enter a profession, not always characterised by its positive media image (Takase, Kershaw & Burt, 2002).

Knowles (1980: 50) suggests that:

Adults ARE what they have DONE.

Howkins & Ewens (1999) indicate that past experiences of the individual are a major resource in learning situations and the adult can approach learning only from their own life perspective. Although I seem always to have been aware of the importance of my life experiences in shaping the way I view and approach situations, albeit at a subconscious level, I found it reassuring to find literature reaffirming my beliefs. Possibly the palette of my life to date has shown me that one (I) can only view life from a personal perspective and that it is one's (my) experience which makes one (me) who one is (I am). I realised in reading this literature that I felt that (nursing) education takes little of the adult experience into account. I recognised the concept of development as discussed by Knowles (1980) in my own continual need to understand, but I found that I was not sure how this worked in the bigger picture. I sought, therefore, to find more information by understanding the concept of adult learners.

The motivation to learn is another complicating factor in dealing with the challenge of adult learners. Barriball, While & Norman (1992) and Pedan, Rose & Smith (1990) suggest that the success of any form of schooling is dependent on a need for change coming from the individual rather than it being enforced by the organization – clinical placement or school. Yet it would appear that pressures within different practice settings influence the student's degree of learning in the workplace (Wilson & Startup, 1991; Philpin, 1999; Farrell, 2001; Last & Fulbrook, 2003; Randle, 2003a).

A registered practitioner is expected to be self-aware, reflective, self-critical and responsible (Nursing and Midwifery Council, 2004b). These characteristics imply the need for the adult learner's self-concept to move from dependency to independency as the individual grows in responsibilities, experience and confidence. The dimensions discussed by Knowles (table 2.1) add up to a quest for self-actualisation and tie in with the perception that learning is an individual and transformational process.



<b>From</b>	<b>Toward</b>
1. Dependence	Autonomy
2. Passivity	Activity
3. Subjectivity	Objectivity
4. Ignorance	Enlightenment
5. Small abilities	Large abilities
6. Few responsibilities	Many responsibilities
7. Narrow interests	Broad interests
8. Selfishness	Altruism
9. Self-rejection	Self-acceptance
10. Amorphous self-identity	Integrated self-identity
11. Focus on particulars	Focus on principles
12. Superficial concerns	Deep concerns
13. Imitation	Originality
14. Need for certainty	Tolerance for ambiguity
15. Impulsiveness	Rationality

*Table 2.1: Dimensions of maturation (Knowles, 1980: 29)*

The point of departure in this discussion should be the informed decision of an adult choosing a particular study direction, and Spouse (2001) illustrates the change and variation in what is learned throughout the duration of the nursing course.

Behavioural tendencies among nurses suggest that the dimensions suggested by Knowles are not generally represented within nursing education. This may be caused by a number of factors: first, the paternalistic status of nursing in relation to the medical discipline, which has socialised nurses to be non-assertive (Maykovich, 1980); secondly, the fact that nursing has traditionally been subject to a passive form of education (Dolan, Fitzpatrick & Herrmann, 1983; Nicklin & Kenworthy, 1995); finally, the fact that the method of evaluation has been based on a course product rather than on the integration of theory in practice (Franke, Garssen & Huijer Abu-Saad, 1995; Nolan, Owens & Nolan, 1995).



Both Knowles (1980) and Kolb (1984) describe learning as being the interaction of the individual with the environment. The student is, simultaneously, both a neophyte to the nursing profession and a student needing to learn from practice. In both roles the student needs to be assessed and is therefore in a doubly dependent role. The need for feedback and support from the clinical environment is obvious in order to develop (MacIntosh, 2003). If the clinical environment is as hostile as described by Randle (2003b) and Farrell (2001), this could magnify the student's perception of dependence.

This indication of dependence is causing Peter to raise the issue of power and authority in Philip's choice of nursing and teaching.

Does this concept of there being dependence on an 'in- or out-crowd' still ring true for me and for students entering nursing? Is the history of potential martyrdom derived from the underlying notion of altruism in nursing? Are the wise women from centuries ago still haunting modern-day nurses? Could my choice to work as a nurse and an educator be linked to the idea of having patients and students dependent on me? Or was there, perhaps, a level of my being that recognised my own educational and dependent background and was wanting to provide the students with a better deal – a case of what parents don't have themselves, they want to provide for their offspring? I find that I feel uncomfortable with this idea – can one not simply choose a career without some psychologically ulterior motive? I suppose the motive may not always be ulterior, but it would probably be influential. I would feel a sham if I were ultimately to realise that my life's work has actually not been as altruistic as I'd always imagined. My feeling of being included in an exclusive group and being respected because I 'do such good work as a nurse' has always been part of the perks of the job. Peter is smiling at my new form of questioning – I need to look more closely at actions. And so my literature search took me to explore the concept of behaviour.

### **Behavioural change and dependency**

Some authors substantiate the belief that the student's experience influences learning and personal attitude. The individual's experience, in relation to their perception of social norms and pressures, can be seen as a prerequisite to learning and behavioural change (Ajzen & Fishbein, 1977; Damoiseaux, van der Molen & Kok, 1993). The importance of personal intention to allow behavioural change is illustrated by Urbano & Jahns (1988) and Urbano, Jahns & Urbano (1988), who suggest that the motivation to change is based on personal needs centred on the perceived gap between present and ideal levels of attainment and positive reinforcement from significant others.

When taking Knowles' (1980) 'Dimensions of Maturation' (table 2.1) into account, it is clear that an educationalist in both academic and clinical areas has an important responsibility to build the student's self-esteem. Espeland & Shanta (2001) discuss the role and responsibility of the nurse educator with regard to empowering students and cite Glass (1998) as suggesting three necessary components:

... the raising of consciousness, the development of a strong positive esteem, and the political skills need [sic] to negotiate and change the health-care system.

The idea of educating the student to change the status quo requires the academic and ward staff to want to change practice themselves and 'use' the student as a change agent in the most positive way – the student is then a source of new (theoretical) ideas and of ideological inspiration. Unfortunately, this is not the case in many instances. Education tends to dictate rather than coach (Carlson-Catalano, 1992; Clare, 1993a; Litchfield, 2001; Leyshon, 2002) and registered staff in the practice settings appear threatened when confronted by change (Randle, 2003a).

Espeland & Shanta (2001) suggest that faculty staff confuse 'empowering' with 'enabling' and often provide too much support to students, resulting in a form of interdependency between student and staff. This initial relationship built between faculty and student in the academic setting can provide the student with a 'false' sense of security and lead to a cultural shock when confronted by the realities of the clinical setting (Smith & Gray, 2001a; Spouse, 2001). The student needs to be prepared to deal with the demands and rigours of the nursing profession, to have the courage to operationalise a personal philosophy of care and to be able to liaise with colleagues in the ward setting without adapting thoughtlessly to the new situation or feeling victimised (Johns, 1995; Holland, 1999; Watson, Deary & Lea, 1999; Smith & Gray, 2001b; Stickley & Freshwater, 2002; MacIntosh, 2003).

Randle (2003a) and Farrell (2001) both indicate that (student) nurses are not assertive when confronted by authoritarianism. Historically nurses have been selected on the basis of their submissive and non-assertive character traits rather than their intellectual prowess, and these 'nursing characteristics' appear to have been propagated through to the present day (Wilson & Startup, 1991; Birchenall, 2003; Kirby, 2003; Lorentzon, 2003).

It is possible that nursing students, entering into practice placements and feeling insecure and dependent on others, place value on them as neophytes and so develop a behavioural pattern which can be classified as being co-dependent.



The concept of co-dependency in nursing makes me reel. It opened all manner of issues in my relationship with my mother and 'significant others' (I hate that term. It implies so much and, yet, is so impersonal in its jargon.) Could this have been the reason for my entering nursing? Was my continual focus on empowering students and colleagues actually a form of co-dependence by making them dependent on me rather than supporting them to become independent? Peter's new questions are making me curious – and a bit apprehensive about what I will find out about nursing and co-dependency.

I wrote:

In past years perceptions of the environment and the resulting influence they have on the individual nurse have caused authors to speculate that co-dependency could be a complicating factor in the nursing profession. In an exploratory study using the Friel Co-dependence Assessment Inventory and the modes of Roy's adaptation model, Chappelle & Sorrentino (1993) show that while 160 nurses show responsibility, 65 show varying degrees of co-dependent behavioural characteristics. Bennett, Robertson & Moss (1992) quote published co-dependency figures among nurses as ranging between 75 and 90%. They suggest that nursing serves, by virtue of its caring nature and its altruistic and ascetic origins, to attract those with a disposition to co-dependency (Sherman, Cardea, Gaskill & Tynan, 1989; Hall & Wray, 1989; Malloy & Berkery, 1993; Yates & Mc Daniel, 1994).

However, more recent literature questions these figures. Hopkins & Jackson (2002) and Martsof (2002) suggest that this is not the case. Hopkins & Jackson (2002) found the incidence of co-dependent behaviour among nursing students no higher than among their contemporaries on other courses – they were, however, researching students and their learning in the academic setting and not in the hospital setting. Biering's (1998) findings, using a cohort of eight registered nurses, indicate that these nurses, coming from dysfunctional families, had developed skills which could be put to good use within the health-care setting and the findings do not support the assertion that these nurses were co-dependent in their own behaviour.

I feel a sense of relief. Whether (student) nurses can or should be labelled as being co-dependent is not of particular importance. Nurse educators should rather recognise the need to empower students in becoming more assertive and allowing them to challenge the routines and rituals they encounter. Developing assertiveness in students can be seen as being positive, but this is not without risk. As already discussed, Espeland & Shanta (2001) discuss the dangers of dependency between student and faculty, while Philpin (1999), Farrell (2001)



and Randle (2003a) discuss the (student) nurse's dependency on colleagues in the clinical placement areas. According to Leyshon (2002), while seeking to break the status quo, educators do not actually provide the support students (or registered staff) need in re-establishing a new balance. This often leads to one authoritarian system being replaced by another. For the moment Peter has been silenced.

### **SECTION THREE**

## **Socialisation and culturalisation**

In much of the nursing literature 'socialisation' processes are discussed when referring to workplace-specific situations. This can lead to some confusion as adaptation to and integration into a society can be quite different from the adaptation to and integration into a culture within that society. Many cultures can coexist within a society and within the context of this study it is important for me to differentiate between socialisation and culturalisation issues.

Carrithers (1992) quotes Wolf (1982) as defining a society as:

changing alignments of social groups, segments and classes, without either fixed boundaries or stable internal constitutions (Carrithers, 1992: 27).

Carrithers (1992) defines sociality (the tendency to associate with others and to form social groups) as "an inherited trait" specific to individuals and possessing characteristics specific to the population they are part of. With regard to human beings, Carrithers sees sociality as 'a capacity, a potential'. This can also be said of the sociality of nurses, namely that individuals, possessing specific character traits, gravitate towards nursing, therefore creating a 'nursing society'. Specific characteristics possessed by nurses such as being of 'good character and behaviour' and being a 'knowledgeable doer', to name a few, have been referred to in the literature and have already been discussed (Sherman, Cardea, Gaskill & Tynan, 1989; Hall & Wray, 1989; Wilson & Startup, 1991; Malloy & Berkery, 1993; Yates & Mc Daniel, 1994; Birchenall, 2003; Kirby, 2003; Lorentzon, 2003).

Adaptation to the specific characteristics of a society can also be seen in terms of 'acting out a role'. Berger & Luckman (1966) discuss the possibility of an individual adapting or their capacity to adapt to great degrees in order to become part of a group they wish to belong to and so assume characteristics deemed important by the group. This could be of importance within the nursing profession, considering the findings of Hopkins & Jackson (2001) on the co-dependent characteristics of nursing students in the academic setting when compared with the findings of other authors regarding (student) nurses in the clinical setting (Bennett, Robertson & Moss, 1992; Chappelle & Sorrentino, 1993).



Berger & Luckman (1966) discuss the concept of secondary socialisation in which an individual learns the language and role-specific knowledge, and internalises the tacit knowledge, of what they call a 'sub-world'. This would tie in with the student nurse's submersion and integration into the world of professional nursing (Randle, 2002; Randle 2003a; Randle 2003b).

As with the definition of society described in terms of a process, Carrithers goes on to quote Wolf (1982), who defines culture as being:

a series of processes that construct, deconstruct, and dismantle cultural materials such as social values or ways of categorising the world (Carrithers, 1992: 27).

Later Carrithers suggests that:

culture, here meaning just largely mental goods, forms of knowledge and values to live by, which we have learned or created, is intelligible only in its use by people and in respect of people. Cultures, in other words, presuppose relationships (Carrithers, 1992: 30).

To underscore this approach Carrithers refers to Godelier (1986) as stating that:

human beings ... do not just live in relationships, they *produce relationships in order to live* (Carrithers, 1992: 30).

These are interesting concepts when studying the available nursing literature on 'socialisation' in which inter-collegial relationships are discussed (Randle, 2003a; Farrell, 2001) as they appear (based on the above definitions) to refer to 'culturalisation' rather than 'socialisation' processes (Carrithers, 1992).

Freire (1970) discusses the concept of an oppressed culture in which individuals are dehumanised and brainwashed into believing what others want them to believe. This comes about through the imaging of who is superior – assuming and accepting the hierarchical role definition. Judging from the literature, emotional dependence on a 'superior' who provides the right to exist ties in with the student nurse's dependence on tutors in the academic setting and colleagues in the clinical setting. Students expect mentors to approve their activities, their attitude and their knowledge. Not only is the student reliant on

the mentor's assessment of their capabilities, but they need to be approved of as a person, new to the nursing team and to the profession.

### **Sociological perspective of my study**

It is obvious that in discussing the student's change process, it is important to define the concepts of 'society' and 'culture' from a nursing perspective to prevent the terms being confused. In other words, researchers should be aware of the need specifically to define nursing as either a (global) society consisting of various cultures or, alternatively, as one of the cultures within the health-care society. Within this 'health-care society' which is medically and paternalistically dominated nursing can be seen as one of the cultures (along with paramedical professions) seeking to co-inhabit the space, maintaining a visible and tangible identity and extending boundaries. In terms of this study nursing will therefore be approached as the latter – a culture within the health-care society.

When approaching this study from a sociological perspective, I choose to analyse the student's development within the 'nursing culture' of the 'health-care society' using a structural-functionalist framework. The choice for this theoretical framework is based on literature arguing that nursing and health care are constructed and constricted by routines and rituals (Walsh & Ford, 1989; Ford & Walsh, 1994) and are therefore resistant to change – this appears to fit the theories espoused by Parsons and Durkheim. This framework provides a clear, but simplistic, model to categorise the data collected and analyse the relationship between the societal subsystems. Later models of structuralism and theoretical frameworks illustrating society as characterised by change and diversity incorporate 'conflict' as a concept inherent in the society, but this does not reflect the passivity inherent in nursing as a group in relation to outside influences.

Both Durkheim and Parsons based their ideas of the structural-functionalist theory on the assumption that a society is underpinned by a strong value system and that the members of a society are morally bound to maintain equilibrium by being true to the agreed roles (Fulcher & Scott, 1999). The roles are developed and underpinned by group consciousness and shared norms which result in a set of values. These norms and values form the foundation of the society which all members are expected to accept and adhere to. Failure to do so is considered morally unacceptable.



Parsons (1982) discusses the concept of equilibrium from the point of 'functional prerequisites'. Four problems have to be resolved namely: (a) adaptation to the environment, (b) goal attainment, (c) integration, and (d) pattern maintenance and tension management. Taking this Parsonian approach further, the 'health-care society' can be seen as having four main structural features necessary to maintain its existence and viability – the subsystems economy, politics, cultural organisations, and kinship and community (Figure 3.1) (Fulcher & Scott, 1999).

	Means	Ends
External Aspects	a. ADAPTATION Economy	b. GOAL ATTAINMENT Politics
Internal Aspects	Kinship and community d. PATTERN MAINTENANCE & TENSION MANAGEMENT	Cultural organisations c. INTEGRATION

*Figure 3.1: Social system based on Parsons (Fulcher & Scott, 1999)*

Specific to nursing education and health care, the functional prerequisites can be seen as the individual student nurse's **adaptation** to academic and clinical settings in a literal and physical sense and the sometimes differing behavioural patterns the two settings demand. The **goals** that are to be attained can, again, be very diverse and range from achieving academic grades and psychomotor expertise to meeting production levels in the clinical field whilst providing client-centred, philosophically sound care but not always having the time and/or knowledge resources to achieve this. Within the health care team in general and the nursing team in particular it would appear that there are specific roles for specific players and the success of the team effort is dependent on the individual's **integration** into their role. Diversity in interpreting this role will result in chaos in both the uni- and interprofessional teams which will, in turn, affect productivity and hence the viability, credibility and stability of the 'society'. Linking to the stability necessary for this health-



care 'society' to remain viable, the society needs mechanisms to ensure that members **maintain the pattern** and status quo and remain within their preordained roles, meeting the goals demanded of them – within nursing education this can be strongly linked to the system of (clinical) assessment and evaluation and could explain the differences between medical and surgical units as perceived by students, often based on the type of productivity expected of them (Philpin, 1999). This system of culturalisation into various units/wards, underpinned by the continual pressure to adapt to different environments and achieve goals specific to particular units, demands that students learn to adapt and meet what is seen as being important on each unit rather than learn to provide care based on a humanistic and holistic philosophy.

The external influences on nursing and nurse education and therefore on the development of the profession can be related to the **economic and political** subsystems driving the health-care 'society'. Budgets for academic (Gray, 2002; Kenny & Kendall, 2001) and clinical (Elliott, 2002) education are continually being reduced and replaced with drivers related to production figures, and perceptions and experiences of health-care users are used to manipulate (nursing) staff into believing that their quality of care is deteriorating (Duffin, 2005). They are pressurised into having to produce more (a higher level of care including tasks/responsibilities from other disciplines) with fewer resources. This in turn does result in a reduced quality of care and further fuels the political drivers. Although the economical and political drivers do not have a direct effect on the individual student, they do influence the clinical and academic environments and therefore dictate possible limitations or opportunities experienced by the individual student. In this way they are influential (Percival, 2005; Philpin, 1999).

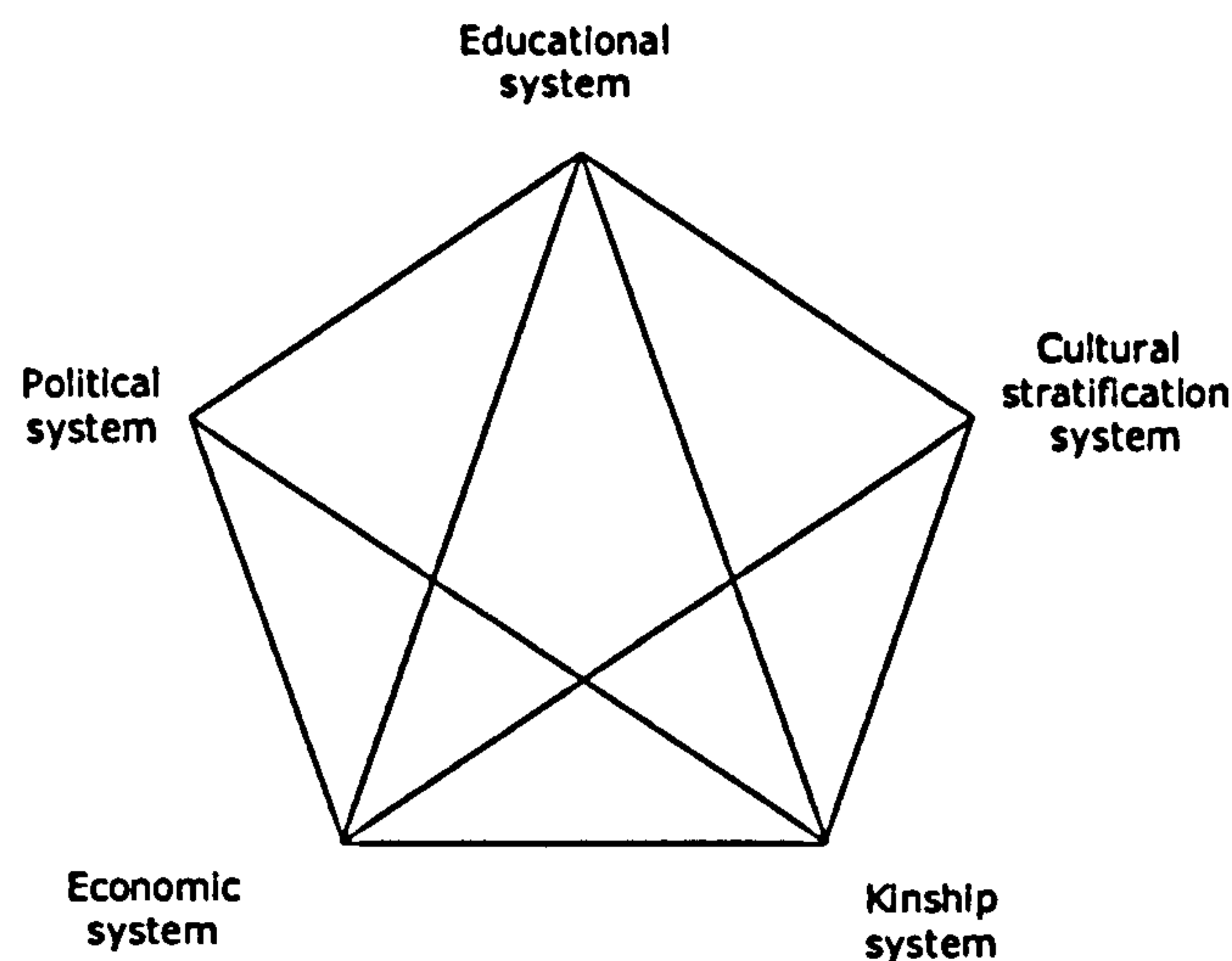
**Nursing kinship** and the **cultural organisation** subsystems of the health-care society go hand in hand. Most individuals entering the nursing profession do so from a basic philosophy to care for others and, simplistically, this can be seen a value linking nurses and often other health-care professions and professionals (Jones, 2002; Pendleton & King, 2002; Mackintosh, 2000). Actual or perceived deterioration in the quality of care can undermine the norms and values of the professional groups and result in individual and group stress (Duffin, 2005; O'Brien-Pallas et al., 2004; Gillespie & Melby, 2003). One of the fundamental values underpinning nursing is the concept of the nurse as the patient's advocate and coordinator of care, so deterioration in

the quality of care can be seen as a direct responsibility of the nursing profession.

With regard to the cultural organisation of the health-care society, different 'cultures' such as nursing, medical, paramedical, administrative, housekeeping, and so on, need to interact and interrelate if the 'health-care society' is to be kept in equilibrium. However, dichotomies within health care such as medical/nursing models, cure/care paradigms, principle-based/care-based ethics, etc. can result in the polarisation of professional groups. This need not always be a negative influence as discussion on the patient's behalf from different/opposing perspectives could serve to explore fully the options open to the patient and provide the health-care professionals with opportunities to reflect on the care offered by their specific professional group (Faugier, 2005; Esterhuizen & Kooyman, 2001; Widdershoven, 1999). A potential danger arises when resources are reduced to a level affecting the quality of (nursing or medical) care in an individualised 'blame-culture' characteristic of most Westernised countries. The members of each of these cultures resort to protecting their own interests and so enter into competition with one another (Hehir, 2005). Another anomaly within the system is the concept of the nurse functioning as an autonomous professional and coordinating the various disciplines in providing optimal care for the patient. Within the health-care society the nursing profession (culture) often has the lowest status, which, in itself, results in a remarkable contradiction – the responsibility to coordinate care, but the lack of authority to resort to any form of action if there is non-compliance from the other professions (cultures). Also, it is questionable as to the degree of autonomy open to nurses when viewed within the current medical model in which medical practitioners largely carry the authority and ultimate responsibility for health-care resources (Gallagher, 2005; Mrayyan, 2004; Wurzbach, 1996). Confrontation and/or conflict with another health-care profession often has a negative consequence for the nursing profession – either directly or on the basis of vicarious experience – both of which contribute to the perceived (low) status of the individual and group (Randle, 2003b; Farrell, 2001). In his discussion of oppressed cultures Freire (1970) illustrates how members of these cultures internalise the characteristics of the 'oppressor' and resort to forms of violence within their own group – forms of horizontal violence are illustrated in literature focusing on professional socialisation in nursing. This behaviour becomes an element of the culture and 'expected' of the individual – in many ways it indicates status and difference between student and



registered nurse (Randle, 2003a; Farrell, 2001). By internalising the 'oppressed' and 'oppressor' behaviour, members of the culture keep themselves in a status quo and believe that they are unable to change anything in their own situation – this is often inherent in the educational system of such a culture. If this is true for nursing (as an oppressed culture), this mentality results in a lack of critique regarding economic and/or political issues. This, in turn, will prevent fundamental change and development within the professional group (culture) and 'cultural' change and development within the health-care 'society' (Tinsley & France, 2004; Freshwater, 2000).



*Figure 3.2: Model of social structure (Fulcher & Scott, 1999)*

Approaching the discussion of professional 'socialisation' from a sociological perspective and based on the 'negative' accounts of student nurse socialisation as often described in the literature, it would seem plausible to approach the discussion from the perspective of a structural-functionalist theory. From this perspective the social structure of health care would need to be dependent on equilibrium and role definition (figure 3.2) – two issues that appear to influence health-care 'society' in broad terms, but also the ward-based culture in a more specific context.

I think that a structuralist framework could provide a clear and conveniently arranged model for analysing data obtained in this study, but this immediately highlights the first of two primary limitations of this approach.



To approach the process of professional socialisation from this simplistic interpretation would not do justice to the complexity of the interactions contained within the health-care community. Although perhaps influenced by constraints, individuals are bound to their roles by symbols in their interactions with others and their environment (Cohen, 1985; Berger & Luckman, 1966). They use methods of interaction, reflection and reflexivity to understand and adapt to their work environments, so to negate this essential element within the study would jeopardise its value.

A second limitation in using this framework is the restricted focus on the student's educational process. Considering the fact that the participants are students and engaged in a programme to prepare them for a professional role, it would seem appropriate that the study should place the student's learning centrally.

I doubt whether a sociological perspective would cover the area of my research adequately. I need to investigate the possibilities and impact of approaching my project from an educational perspective.

### **Education**

The role of nursing education, the way in which information is presented and the methods of assessment and evaluation used do not inspire empowerment and can lead to subservient and non-assertive registered staff (Maykovich, 1980; Dolan, Fitzpatrick & Herrmann, 1983; Nicklin & Kenworthy, 1995; Carlson-Catalano, 1992; Clare, 1993a and ; Espeland & Shanta, 2001; Litchfield, 2001; Leyshon, 2002). Freire (1970) takes this idea further and suggests that a passive form of education in which students are not taught to think independently leads to oppression. This could be the link, as previously suggested, with the history of nursing education being rooted in vocational learning.

Reflective learning and critical thinking have been important developments in nursing education (Paul & Heaslip, 1995; Johns, 1998; Lyons, 1999; Platzer, Blake & Ashford, 2000). Jarvis, Holford & Griffin, (1998) suggest that although reflective learning and critical thinking take place within a cultural context, they do provide the learner with a more sophisticated approach to learning and the learner is more apt to question the status quo.

However, often to satisfy academic systems, students are required to present their reflective and critical thinking in an assignment form – a form that in itself offers discussion in the socialisation/culturalisation debate.

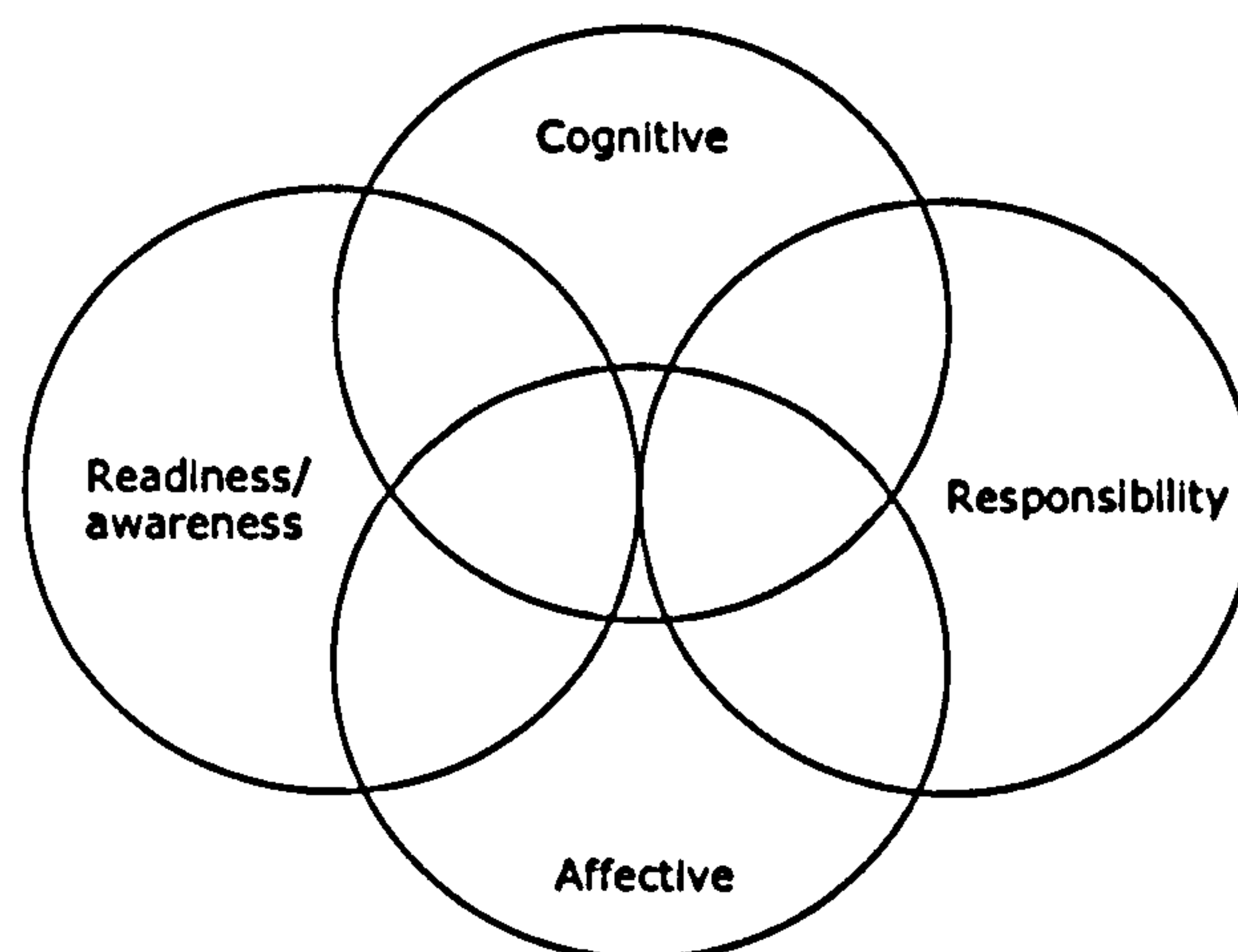
On the one hand, through attempts to develop a system of grading for reflective narrative, it would appear that nursing education is seeking a format to harness the free thinking of the modern student, regain control and supervise direction of the students' growth (Watson, 2002). On the other hand, ideas and perceptions of reflective narrative being shared with tutors and other parties magnifies the vulnerability of the student (Cotton, 2001), but they also question the deconstruction and analysis of the narrative on the part of the tutor as undermining the student's development (Pryce, 2002).

These two illustrations dealing with the (academic) outcomes of reflective practice and critical thinking form a dichotomy. The first could be seen in attempting to maintain the status quo and 'prevent anarchy' within a 'society', while the second could represent support of a 'cultural revolution' stimulating change. This approach can easily be seen in terms of a Parsonian social system in which student's goals are directed in terms of adapting to the nursing 'society' to meet the overarching goal of maintaining equilibrium.

### **Educational perspective of my study**

An educational approach to my study would focus more on the student's process of 'learning' to become a nurse but the student's background and personal values would still play an important role. Owing to the importance of practical placements in general and specifically because the participants are engaged in a programme in which they are continually in the clinical setting experiential learning and confluent education in particular would be the framework of choice with which to analyse the data obtained from the participants.

Two educational models, chosen for this discussion, are associated with **confluent education**. The essence of confluent education is to blend the physico-psycho-socio-spiritual aspects of being human into a single learning process. The central theme, therefore, is the individual learner's Gestalt where cognitive, affective, readiness and responsibility domains are totally integrated (Castillo, 1974). This essentially holistic approach is in keeping with current nursing philosophies (Watson, 1988; Benner, 1984).



*Figure 3.3: The "four circle" model (Castillo, 1974)*

The first confluent educational model described by Castillo (1974) identifies four domains (figure 3.3) – **cognitive** (mind), **affective** (feelings), **readiness/ awareness** and **responsibility**. Besides cognitive and affective aspects, Castillo's model allows the educator to isolate important factors affecting learning. Castillo (1974) suggests that the domains of mind and feelings are directly interrelated both with each other and with the other two domains. It is, however, the degree of readiness/awareness of an individual that leads to their responsibility. Castillo is of the opinion that these two domains do not share a direct interrelationship, but are interrelated via the cognitive and affective domains. Owing to this interrelationship, a total integration is obtainable by an individual. The two areas of readiness (to deal with intellectual demands) and responsibility (being able to carry out the tasks required) can be seen as being characteristic for students who are, at the same time, adult learners and carry the responsibility for patients while learning to become nurses.

The second model to be discussed provides insight into the holism of confluent education. Brown, Phillips & Shapiro (1976) base their discussion on experiential learning in Yeomans' model (figure 3.4).

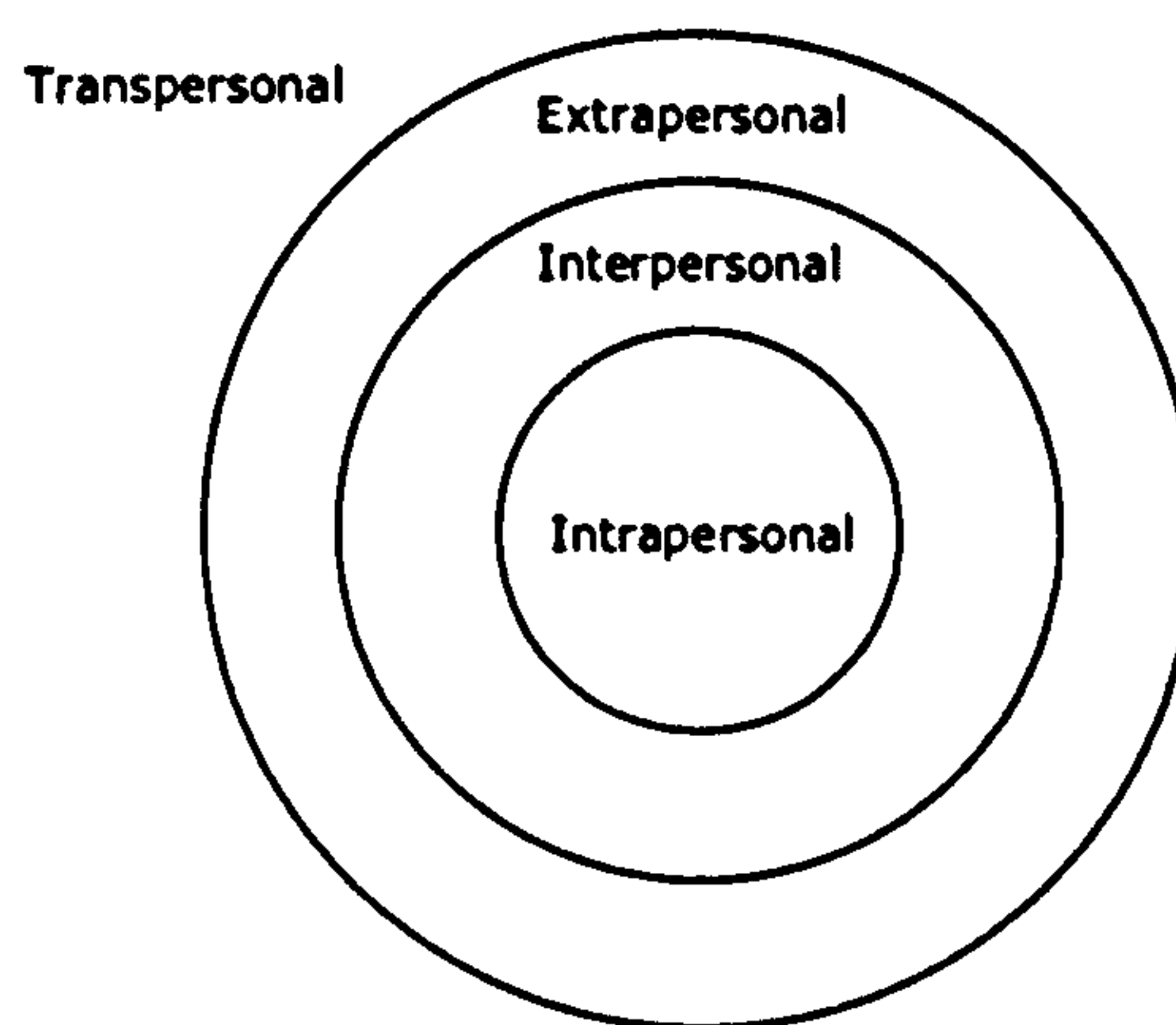
Starting with the inner area of **intrapersonal** functioning, the individual can be characterised by the different roles and personal attitudes they hold. In the confluent concept of education, the learning cycle of Kolb (1984) gives form to this area of intrapersonal functioning. In comparing the two models Yeomans' intrapersonal functioning as discussed by Castillo is limited to the aspects of mind and feelings.



Responsibility as described by Castillo (1974) fills the area of **interpersonal** functioning and Brown, Phillips & Shapiro (1976) describe this area as the interaction between the individual and those in their environment.

Readiness in Castillo's (1974) model correlates to Yeomans' **extrapersonal** functioning – the contexts in which people learn.

Finally, Yeomans' model of confluent education occurs within a matrix of **transpersonal** functioning which forms a philosophical/spiritual context for the intra/inter/extrapersonal interaction. This all-encompassing concept is not specified in other experiential learning models.



*Figure 3.4: Confluent education – Tom Yeomans (Brown, Phillips & Shapiro, 1976)*

Using an educational perspective to enter the discussion on professional socialisation, I discover two issues that need to be taken into account. First, the student is not only learning the knowledge and skills needed for the profession, but the assumption is also that the student has entered the nursing programme with a desire to care for others and will be developing an individualised philosophy of care – this is fundamentally a moral development. This interfaces with the second issue - the fact that the student is an adult learner and is, therefore, in the process of moving through the dimensions of maturity (Knowles, 1980) and striving for self-actualisation through the lived experience of providing care (Nåden & Eriksson, 2000; Smith & Gray, 2001a; Smith & Gray, 2001b; Nåden & Eriksson, 2002; Stickley & Freshwater, 2002; Nåden & Eriksson, 2004). This personal growth necessitates an educational model that incorporates a holistic approach to education. Confluent education has previously been discussed as a possibility for nursing education (Francke & Erkens, 1994) but no publications have been found discussing how these

models could be applied to research. Using these models as a framework for research into nursing education could rekindle the discussion into holistic education and care.

In this study, these two educational models could be used complementarily. The holistic perspective of confluent education illustrated by Yeomans' model can be seen as a contextual framework to place the student in a 'life-context'. And Castillo's model, which fits within Yeomans' Intra-, Inter- and extrapersonal areas, can be used as a more detailed framework to analyse the individual process of learning which takes factors of the student's 'life-context' into account. The combination of these two models – the full spectrum of confluent education – would incorporate both the educational and the sociological perspectives of this study.

The student's experience of an educational programme and the way in which they adapt to their environment cannot be seen or discussed in isolation. I find it, therefore, essential to be clear on the approach my discussion needs to adopt.

However much they overlap, the difference between an educational and a sociological framework has extensive influence on the research method and, ultimately, on the data analysis.

I am confident that my study needs to be conducted, initially, from an educational perspective. Primarily due to the fact that the participants are students and are therefore in a strong educational paradigm, but also as the educational models I've considered address the holistic development of students and stimulate reciprocal learning more than traditional educational frameworks. I think that the holistic approach encompassed by confluent education is a possible way forward to change both nursing practice and the practice of nursing education.

Peter has been silenced again by my arguments to underpin my research with arguments that support an appropriate approach and well chosen frameworks. To prove my point I can illustrate the way different research objectives would highlight different issues when placed specifically within the context of sociological and educational perspectives (table 3.2).



	<b>Educational perspective</b>	<b>Sociological perspective</b>
1	Explain the individual's motivation to enter/study nursing from an adult learner perspective with a view to self-actualisation and the motivation to care.	Explain the sociological and cultural motivation of the individual to care for others (including possible issues such as co-dependency and sociality).
2	Differentiate the implications for the adult learner having to learn to link theory and practice in a (semi-)worker's role while dealing with the responsibility for vulnerable others and needing to adapt their learning style to the pre-conceived experiential learning. (These can both be seen as being 'moral' issues. The potential tension this could cause could also be termed 'moral' when viewed from the adult learner's perspective and their movement through the dimensions of maturation. Failure could have a lasting impact on the individual's development.)	Differentiate potentially different levels of moral impact experienced by the student during the process of learning. (This could range from the expectation to provide high quality, patient-centred care with a minimum of time/knowledge resources. But could also result from dealing with vulnerable others and being faced with having to make decisions that could have far-reaching effects and results.)
3	Explain how the individual copes with internalising professional values, while at the same time undergoing a transformational process according to the dimensions of maturation (Knowles, 1980). (This could also link to development of Emotional Intelligence in having to deal with/ understand the personal challenges and interactions encountered.)	Explain the risk of alienation from self and significant others by adapting to expectations within the new professional group and how the student deals with this. (This is potentially a risk because the student's motivation to care is embedded within a culturally defined set of values which may differ from professional values. Adaptation could result in identity crisis for the individual.)
4	Explain how the student develops a 'caring philosophy' as a route towards self-actualisation and achieving the dimensions of maturation as described by Knowles. (Assumption – this may be more related to socialisation into the global nursing profession.)	Explain how the student develops a personal 'caring philosophy' taking into account that from a sociological perspective the student will be expected to adapt to 'accepted' professional values. Also taking into account that the student will potentially want to carry out what is expected by the group in order to 'fit in', but will also want to live up to personal values and a predefined role specification. (Assumption – this may be more related to culturalisation into local health care cultures and not the global nursing profession.)

*Table 3.1: Educational and sociological issues underpinning the study objectives*

I am confident that my arguments highlight my choice to approach the research from an educational perspective and substantiate my motivation to change the dynamics of



nursing education rather than to be reactive, self-indulgent and self-absorbed as Peter has suggested by his questions.

### **My experience**

Reflecting on my process since the outset of my study in 2002, I can see that my research has changed dramatically. More specifically, I can see the change in my approach since the initial meeting in November 2003. I have aims and objectives related to the student experience similar to the ones I started with initially. However, I now have new objectives that focus on me and my personal and professional development. I want to know what has driven me as a nurse and an educator and how my life experience and being have impacted on how I've interpreted my role. This recent development and insight have affected the aims and objectives of my study.

Pollner & Emerson (in Atkinson et al., 2001) discuss the importance of the researcher's 'background understandings' in order to make sense of the participants' experiences. This background understanding does risk a bias on the part of the researcher by filling in the blank spaces, so to speak. Reflexivity and journaling during data collection and summarising and paraphrasing during meetings with participants are therefore important issues for the researcher to consider.

The above description of the researcher's (my) responsibility is too measured and distant to appreciate the full extent the responsibility this role entails. My position as a researcher has been discussed at length during supervision sessions – mainly from the point of view that, having worked in the hospital setting for ten years, it was an important change in status within the organisation. Initially this caused me to experience role confusion and entwined loyalties – which have since, largely, been resolved. These were largely philosophical and ethical discussions and reflections – practical and, at times, emotional.

A turning point in my process was the supervisory meeting in November 2003 in which I was challenged to understand the impact of my own socialisation. This meeting marked the beginning of a fundamental change in my approach to the study.

My supervision in February 2006 marked a second shift when I was confronted with actual situations that paralleled those of my student participants – at this point I moved away from the 'objective' research of student experiences to put them into the context of my life and being. I was introduced to the concept of auto-ethnography, which opened new doors for me (Muncey, 2002; Ellis & Berger, 2002; McKenzie, 2002; Berger, 2001; Scott, 1997). My confrontation with myself caused extreme discomfort, but was a catalyst in challenging me

to reflect deeply on who I was – I shall discuss the content of this reflection in detail later in the study.

The fundamental shift in my approach to the research through acknowledging my role as a nurse, an educator and a researcher has caused me to think deeply about what I hope to achieve from my personal experience which runs parallel, yet interfaces with the study focussed on the student experience.

By exploring the impact of my personal and professional life experiences on my role as a nurse educator, I hope to identify how my experience impacts on my interpretation of my role. I shall try to deconstruct my process of professional decision-making as an educator and explore how this interfaces with me as a person.

## **SECTION FOUR**



My progression through this process of doctoral research has been characterised by change and transformation. This means that past, present and future seem to merge but this is how I've experienced my thinking and process to be – a dynamic, retrospective, prospective vision influencing the present. In writing my thesis I have attempted to keep my original ideas intact, allowing them to contrast with and complement the changes in my approach and thinking in the past four or five years. Since setting the aims and objectives, and although I've adapted them along the way, even now I look at them and wonder whether, if I were to start the research with the insights I now have, they would be very different. I have become more reflective and reflexive through the process and have obtained insights I never could have imagined. I have, therefore, resisted the temptation to adapt the initial aims and objectives I set for the study when I envisaged writing an objective account of the student experience.

### **Aim of the study with regard to the student experience**

To explore Dutch nursing students' experience regarding their educational programme and journey towards full nursing registration.

### **Objectives of the study with regard to the student experience**

- (a) Explain the individual's motivation to enter/study nursing from an adult learner perspective with a view to self-actualisation and the motivation to care.
- (b) Explain how the student develops a 'caring philosophy' as a route towards self-actualisation.
- (c) Differentiate the implications for the adult learner needing to learn to link theory and practice in a (semi-)employee role while dealing with the responsibility of caring for vulnerable others and needing to learn from the experience.
- (d) Explain how the individual copes with internalising professional values whilst undergoing a transformational process.

### **Methodological approaches**

Qualitative research is the obvious and most appropriate choice for my study as it focuses on the experiences of the student nurses and me without seeking to quantify or generalise the findings. Besides, it is concerned with investigating and capturing how we cope and deal with reality on a daily basis (Denzin & Lincoln, 2000).

In exploring the student experience, I follow my assumption that a student's needs, perceptions and independence can change during the course of the nursing programme. I

believe that, in order to achieve the depth of understanding I'm aiming at, the study needs a longitudinal approach. Rather than collecting broad and superficial data, I choose to follow small group of students from a single cohort for the duration of their (four-year) BSc Nursing course. My rationale behind a longitudinal approach is that I am able to follow and map the students' developmental process and progress towards becoming a registered nurse.

I need to investigate more fully different options of the qualitative approach that will allow me to understand how students and I make sense of our respective realities. The way in which I have articulated the aim and objectives of my research speaks volumes about my assumptions regarding why students enter the nursing profession and illustrates quite clearly not only my need to understand why I entered nursing 30 years ago but also the projections and expectations I carry with regard to my students and colleagues. I shall incorporate these aspects as I progress through the study and the story of our combined journeys unfolds.

### **Exploration of the student experience**

Owing to the expected complexity of the sets of variables, an 'Ethno Approach' would seem applicable by focusing on cultural and societal issues, within which I'd be able to explore the students' experience from an educational perspective.

Carrithers (1992) suggests that anthropologists transform social knowledge into what he describes as 'another kind of knowledge' and describes ethnography as:

... a style of paradigmatic learning which is closely tied to particular people in particular places at particular times (Carrithers, 1992: 178).

The above definition indicates the contextual nature of this form of study and automatically places it within specified boundaries. Investigation of a phenomenon must therefore occur within a clearly specified framework if sense is to be made of the findings. To frame my discussion regarding the process of change a nurse undergoes from student to registered status, I feel that the changes must be documented within the environments they occur in order to understand them and give them meaning.

The choice of a pure form of research methodology for this project is, therefore, questionable as various methods can be used equally well to investigate specific aspects of the data. Practical issues determine and limit to some degree data-collection techniques and subsequent methods of data analysis.

Because this part of the study focuses on the participant's process and progress from the time of entering the nursing course up until the point of registration, I feel it requires a longitudinal approach to data collection.

I now briefly discuss a number of the ethnographic approaches I considered in order to reach a decision regarding my approach to the study.

Within the scope of investigating the members of a culture or society differentiation is made between, first, Phenomenological Ethnography in which an attempt is made to place 'encounters, events and understandings' in a 'fuller, more meaningful context' (Tedlock, 2000 in Denzin & Lincoln; Maso, 2001 in Atkinson et al.). The researcher's inability to observe the participants in the clinical setting rules out pure ethnographic research; besides, the prime objective of this study is not to describe patterns, typologies or categories within a nursing culture (Holloway & Wheeler, 2002) but rather to explore how people apply rules to everyday life and make sense of social life.

Secondly, an Ethno-methodological approach focuses on the way in which members of a group deal with the written and unwritten rules – in other words, the way 'members actually "do" social life' (Guberium & Holstein, 2000 in Denzin & Lincoln; Pollner & Emerson 2001 in Atkinson et al.). Neuman (2003) describes ethno-methodology as examining social interaction in detail to identify rules for constructing social reality and common sense and how these rules are applied. Neuman (2003) also suggests observing how these rules are used in ongoing social interaction in natural settings.

The appropriateness of the ethno-methodological approach is heightened by the form of data analysis which is characterised by the detailed analysis of short conversations in which the participants' interpretation and understanding of everyday events is explored by using their cultural knowledge and clues from the social context (Neuman, 2003). This methodology uses interview analysis to explore and understand a process rather than describe a single phenomenon, hence the choice not to use a phenomenological methodology.

Although phenomenology is not used as a pure methodology, aspects of phenomenological analysis may be used to obtain an understanding of the Gestalt of the participant experience through holistic interpretation of the interview transcripts and written documentation provided by the participants (Holloway & Wheeler, 2002).

Charmaz (2000 in Denzin & Lincoln) discusses Constructivist Grounded Theory in which knowledge is uncovered as an ongoing process, builds on existing

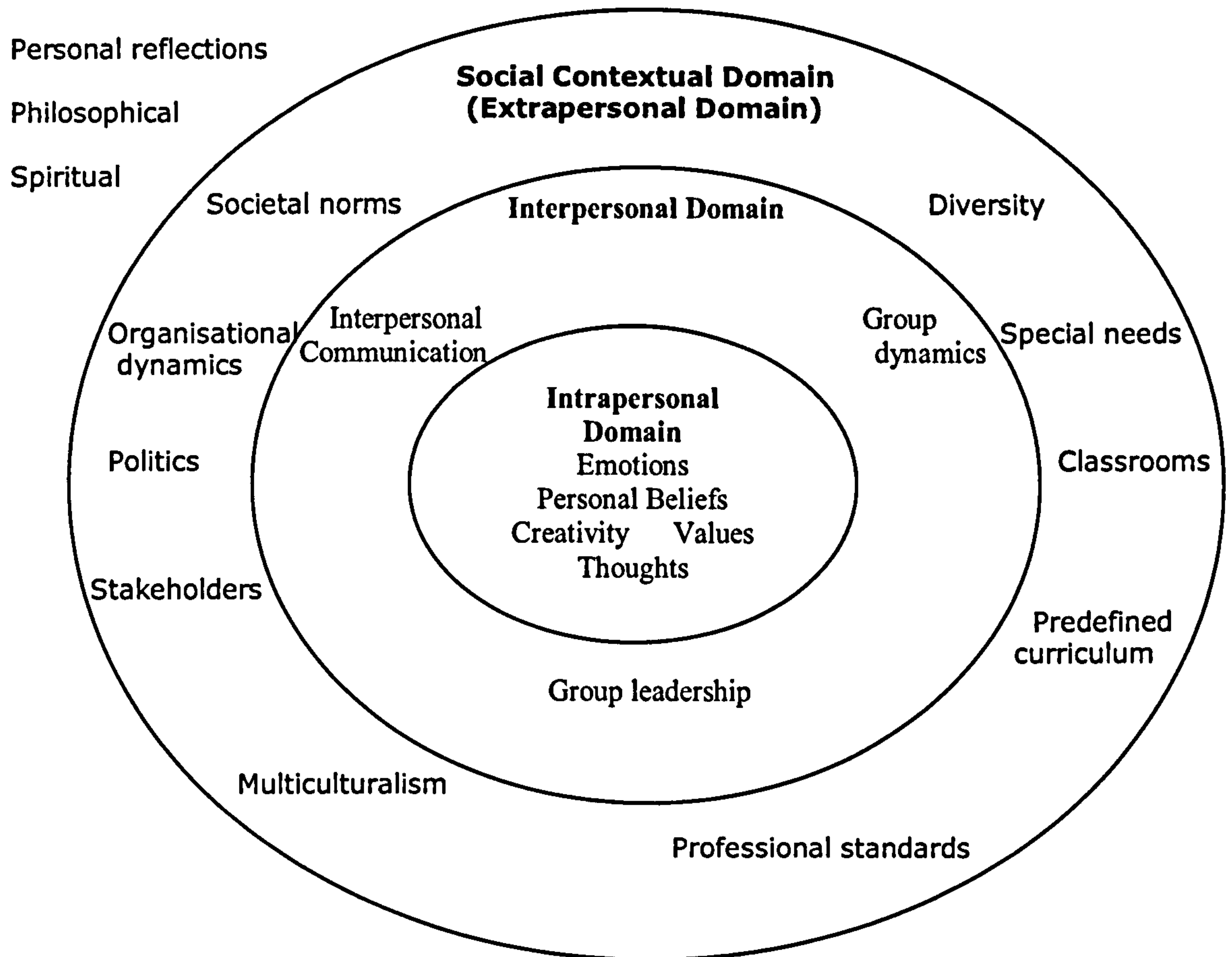


knowledge and provides relativity for viewing multiple social realities. The ongoing and cumulative use of each participant's collected data is significant in this study but is not a form of grounded theory. It is not primarily my intention to generate a theory from the data, but rather to provide insight into the individuals' process and progress towards registered nurse status – however, having said that, it is not improbable that the study's findings may contribute towards developing a theoretical model.

As I've already discussed, my study will encompass two parallel investigations. The student experience forms the first of two important foci of the study, the second being my personal and professional process.

With regard to the student experience, I feel that confluent education is an appropriate theoretical model in which to frame the student's holistic learning process. However, I am acutely aware that the learning process cannot be isolated from the social context in which learning takes place. In the case of the participants of this study, the context of learning is their continuous placement in practice. Their learning is influenced by how the individual student interacts with their environment in the widest possible context – the interpersonal and extrapersonal functioning, according to Yeomans' model (1976). Although Yeomans' confluent education model is an option for framing the data, I have augmented it with more detailed dimensions as defined by DeMeulle & D'Emidio-Caston (2003). The transpersonal dimensions are taken from Brown, Phillips & Shapiro (1976) (figure 4.1).

The detailed dimensions defined by the DeMeulle & D'Emidio-Caston (2003) model provide a more specific framework for the intrapersonal, interpersonal and extrapersonal domains by which to categorise the interview data. This method does, however, fragment the richness of the data and I fear it will be difficult to hone the data to fit into the predetermined dimensions within each domain. The information contained within the interviews is contextual and contains a depth that is lost when reducing the data to loose statements. These statements do not always illustrate the flexibility and complexity of learning across the domains. The symbolic interaction this model implies has a direct influence on the student as they deal with real situations and attempt to make sense of their experiences (Cohen, 1985; Berger & Luckman, 1966) – I see this as being their transpersonal functioning, while I see the more pragmatic aspects of learning as being part of the student's intrapersonal functioning.

**Transpersonal Domain**

*Figure 4.1: Three dimensions of confluent education (DeMeulle & D'Emidio-Caston, 2003), augmented with transpersonal domain (Brown, Phillips & Shapiro, 1976)*

Although it appears, in some ways, flawed before starting, this model does provide a starting point when analysing the data. In order to interpret the data from an educational vantage point within a sociological context it may be necessary to work with other techniques and approaches, be less rigid and take a less prescriptive approach. It is not inconceivable that, by using this framework as a point of departure, but approaching the data more openly, the dimensions defined by DeMeulle & D'Emidio-Caston (2003) could be refined.

In my initial contact with one of the authors I requested empirical underpinning of the model. My questions have, unfortunately, not been answered and I must, therefore, reach my own conclusions about the appropriateness of the dimensions suggested in the model.

### **Sampling strategy in choosing the students for the study**

The group of students I approached to participate in my study are in the same educational programme striving towards the same objectives – they form a cohort panel I use in a retrospective longitudinal survey. This group commenced their formal nursing education in September 2002 and undergo continual clinical placement with an average of two days theoretical education per week. Theoretical education takes place in the academic setting (every second week), but also within the practice setting in the intervening weeks.

Polit & Hungler (1991) and Streubert & Carpenter (1995) describe this form of selection as a system of purposive sampling in which the choice of participants is dependent on the subjective criteria of the researcher. However, it can also be argued that I used convenience sampling to choose the participants (Polit & Hungler, 1991; Holloway & Wheeler, 2002; Neuman, 2003).

According to some authors, convenience sampling is seen to be the weakest form of sampling (Polit & Hungler, 1991; Neuman, 2003); however it is important that the participants were comfortable and willing to speak with me over a long period of time (four years). The participants had to be willing to share their experiences with me and I felt that this could be achieved only through voluntary participation.

This sampling strategy can be seen as a point of weakness in this study as only those students intrinsically interested in participating are included in the study. The issue of inclusion and exclusion criteria has been addressed by other researchers undertaking similar research projects (Melia, 1987; Spouse, 2003), yet from a practical and realistic approach only participants motivated to be part of the study will allow a researcher to interact with them over an extended period of time.

In order to recruit participants, I approached all the students in the cohort, as a group, regarding participation in the research project during their first year of education. I outlined the study and information was provided regarding their time investment, data collection and expectations of their input. The students were not expected to make a decision immediately, but were given ten weeks to think about it. I gave the students my e-mail address and telephone number in the event of their needing further information. They were also provided with an informed consent form which they were requested to sign and return to me if



they wanted to participate in the research project. Of the twenty-two students, nine volunteered to be part of the research project.

At a group meeting ten weeks later, I requested participation again and information was repeated as needed. No further participants volunteered. The nine students who had agreed to participate in the research completed and returned their signed consent forms and I met with these students individually to explain the research process.

In the course of the study the number of participants dropped from nine to five which, in a way, worried me as I was afraid that I would not collect sufficient data. This phenomenon has been a worry for other researchers undertaking longitudinal research among nursing students (Spouse, 2003; Robinson & Marsland, 1994). However, the data I ultimately collected from the remaining five students was so rich that I quickly felt reassured. Thanks to individual and group supervision, I have been able to reflect on qualitative research and its relationship to the dominant positivist discourse. This has caused me to reflect more specifically on the value of qualitative research and the issues of validity and reliability.

### **Ethical approval and health and safety considerations**

I obtained permission from the Head of the Department of Education and Quality Assurance of the Dutch hospital in question to undertake the research within the hospital setting and to approach the students for consent. I did not, within the Dutch system, need to obtain ethical permission from the medical ethical committee. I obtained signed, informed consent from all the participants, providing them with a guarantee of anonymity and assuring them of my discretion. The students were free to withdraw from the research at any stage – this issue was addressed throughout the data-collection process to ensure ongoing, informed consent.

Health and safety issues are minimal as all interviews generally take place within the health-care environment in which all current and relevant health and safety policies are adhered to. Generally speaking, the same room is used for all the interviews and I meet and escort the students from a general area (staff canteen) to the interview room, warning them of the potential danger of the steep, but safe flight of stairs needed to access the interview room adjacent to the chaplaincy offices and chapel. The chaplains are aware that I am interviewing the students and the time that I'll be using the room – I report to them before and after each use. There is a fire exit directly opposite the door to the interview room.

During the interview it is essential that the participant and I sit in close proximity in order to tape record the dialogue as clearly as possible – I explain this to the students in order that there is no misinterpretation of the situation. If the student feels the need to move their chair further away, I place the tape recorder nearer to them and speak louder myself so as not to create any feelings of discomfort for either party. I keep the time spent alone with the students to a minimum and end the interview by asking how the student has experienced the situation. Only after this has been answered do I switch off the tape recorder and immediately open the door to the interview room.

It is possible that the students can become distressed during an interview. If this should happen, the student has the option of stopping the interview and receiving immediate support. This could include support/counselling from one of six gatekeepers who have been approached within the hospital organisation in case a student needs extra counselling: the head of the team specialised in supporting staff who have been exposed to traumatic experiences, three members of the hospital chaplaincy, a philosopher and the clinical educator who is also the group mentor. In the event of a student becoming distressed, I would provide them with a glass of water and tissues if necessary and discuss the situation with them without physical contact – this action is based on known cases of misinterpretation in The Netherlands in which (usually male) staff members have been accused of inappropriate intimacy and sexual harassment. I do not expect any such situation to arise; however, I am acutely aware of the risk involved. In the event of such a situation arising I would discuss the issue while the tape is running, suggest we end the meeting and that the student no longer take part in the research.

Each participant receives an explanation of the research project at the start of each interview and verbal consent is obtained and tape recorded as part of the interview – even though written consent was obtained at outset of the study. I use very little equipment in my research and the tape recorder is battery or mains powered, which reduces risk to a minimum.

As I am undertaking my research in The Netherlands, I am required to travel. The risks involved with the use of public transport fall outside of the research health and safety issues and so I shall not discuss it any further within this context.



### **Ethics and confidentiality in combining research methodologies**

There is an issue regarding participant confidentiality due to the small number of students involved in my study. I understand from the students that they are open in their communication with ward managers if they plan interviews during working time and need to negotiate a period away from the ward, but also that they discuss the interviews they have had with me during peer-group reflective meetings. This is, of course, their personal choice, but it does create issues with regard to anonymity if line managers, colleagues or fellow-students choose to read my research because individual students could be identified. In an attempt to ensure anonymity and involve the students as co-researchers, students were given the opportunity to choose a name they wished to go by in the research. One redeeming feature in this discussion is that the students will all have graduated by the time my thesis is completed, which does reduce the power and dependency issues. This is not, however, an argument in any way to be used in defending the potential breach of confidentiality as it is not, to my mind, an issue of practicality, but one of principle.

A second issue regarding confidentiality is that of protecting the anonymity of the wards. The students have been open in their communication with me and it is important to treat the content of the discussions with integrity. So to maintain anonymity I have coded each of the wards using a letter of the alphabet and any references to patient condition and/or category have been generalised to avoid identification as much as possible.

Realisation of this confidentiality issue has caused me to reflect at length on how to present my research and I find it very challenging – to present parallel case studies would be to potentially expose students to almost immediate identification, but discussing generic themes would compromise the student's individual story. This may be an underlying thought as to why I find presenting my own story as a parallel auto-ethnographic approach appealing as, in this way, I may be able to focus the discussion on my role, using the student situation as an example.

Peter is yawning broadly – self-sacrificial? Philip is drawing a blank card at this stage. I don't think I am being a martyr to the cause as I believe that by focusing on my role and decision-making I shall highlight issues for the student and the validity of the situation for student and educator.

Holloway & Freshwater (2007) suggest that a participant's active role requires a more acute sensitivity to ethical issues. They go on to discuss the importance of keeping participant



narrative in context and remaining true to what has been said. In an attempt to achieve contextuality acceptable to the students I sent them a draft copy of the thesis to read – not as a form of validation, but to inform them ahead of time of how their input was being used and to place it in the context of my work. They were clearly informed that any comments they had may either be included in the thesis as a post-script or, alternatively, could form part of a publication at a later date.

The same authors go on to suggest that researcher interpretation of participant data could affect the participant's understanding of their experience (Holloway & Freshwater, 2007). The student's understanding has, naturally, already been altered to some extent during the interview process as the student/researcher interaction is intersubjective and Socratic – but there is a different dynamic between the word spoken in private and the written word published in the public domain. I am also aware that items that have acute relevance to the participant during the interview will be perceived differently by the end of the reflective session, and will be perceived even more differently a week or month after the session. This means that by the time the student, manager or colleague reads the account of a situation in my thesis, their perception of the reality of the moment will have changed and possibly be dated. The risk of confronting participants with my interpretation of their changed reality substantiates the choice to use my experience as the focus of the discussion and use contextual situations offered by students as catalytic. By integrating the students' experiences with mine I feel that I can illustrate their socialisation process via my personal narrative. Naturally, I can argue that in presenting my story I am still only providing a snapshot of my thought process. This is true, but I shall be in a better position to elaborate more fully in my personal narrative.

Furthermore, Holloway & Freshwater (2007) go on to discuss the concept of using narrative as a method of empowering a marginalised group. I feel that, in the context of my research with the students, this would be an arrogance I could not defend. I don't believe that I may assume that the students need empowering or even that they are marginalised – with the insight I've gained in the past years, I may well have marginalised myself. My research could, therefore, mean that I will be using narrative to empower myself – in which case it would be unethical to use the student experiences for my own benefit.

Peter is again silent, but not for long. He refers to Pryce (2002), who suggests that reflective practice and narrative journaling is a symptom of a voyeuristic society. What would he make of a combined ethno-methodological/auto-ethnographic research combination in which the researcher takes centre stage?

Is it self-indulgent? Am I a product of a voyeuristic society, even though I loathe reality TV and seldom watch anything of that genre?

How do I feel about auto-ethnographic research? Is it a form of self-indulgent, voyeuristic exhibitionism? In some cases it may be. Perhaps I should start by articulating what I think auto-ethnography is - I reflect on this more and on what Caroline Ellis (2004: xix) says about auto-ethnography:

...research, writing, story, and method that connect the autobiographical and personal to the cultural, social and political.

I'm aware that my interpretation of auto-ethnography and the way I use it highlights that it is not only a research methodology – the process, but that it is also the product. By journeying through the research process and striving to make my decision-making as transparent as I can, I can achieve insights and understandings that would, otherwise, remain hidden. According to Ellis & Bochner (2000) this could be termed as being reflexive ethnography as I will have used my own experiences as a practitioner, an educationalist and a researcher within a nursing culture to reflect on myself and my interaction with others.

By sharing my story, I attempt to clarify the experiences of the students participating in my study. In some ways this approach could fit within a Feminist perspective. But then again I'm aware that I've not incorporated *all* aspects of my life as would be the case in an auto-ethnographic study if I were, primarily, researching myself.

It was never my purpose to approach the research with the intention to provide an exposé of myself as a person. The auto-ethnographic strand of my research evolved as a methodological attempt to provide transparency, rigor and trustworthiness using a post-modern approach as suggested by Tierney (2002), Soobrayan (2003), Pillay (2005) and Jasper (2005). I am aware of the risk that participants can disappear in a flood of researcher narcissism which is the reason that I placed my story within a separate narrative and focused on the individual student's stories in separate sections. I have been as transparent and as truthful as I know how with regard to my ideas and beliefs along the way – I believe it is only possible to provide any interpretation of the student's stories when it is placed within the framework of my way of thinking and life world.

I wonder, with Peter at my shoulder again, whether I'm trying too hard to defend the choice to include myself in the study. I don't think that I should – I think there is a nuance in the way auto-ethnography is used – whether it is the primary focus of the



research, or whether it is an instrument used to provide clarity and transparency. I am confident that I have used it as an instrument to spotlight ‘my’ students.

### **Validation and intersubjectivity with regard to student experience**

Denzin & Lincoln (2000, in Denzin & Lincoln) discuss the fact that qualitative research should not be triangulated in an attempt to provide validity for data, but rather to attempt an in-depth understanding of the findings arising from the research question. However, considering the tension and discussions relating to the acceptance of qualitative research findings within a positivist-dominated research arena, Kermode & Brown (1996) discuss the importance of qualitative nursing research being able to stand up to the rigours of critique if it is to stay within the broader discussion of scientific research. Instead of a longitudinal research approach using different designs to create a form of research triangulation (Risjord, Dunbar & Moloney, 2002; Ruspini, 2002), the use of multiple methods of data collection lends an increased validity and reliability, considering the subjectivity of the student’s experience. In the case of this study these are interviews, reports and documentation, and observations conducted during the interview.

Interview transcripts are often presented to participants to verify their answers; however, Oiler (1982) maintains that ‘knowing shapes experience’ and Burnard (1995; 1996) discusses the risk involved in attempting to ‘find reality’ in a text. This implies that the participant, through the experience of being interviewed, ‘comes to know’, which influences the interpretation of their ‘objective text’ being presented to them for validation by the research in the form of a transcript.

The ‘expectation’ to provide validity and reliability with regard to the transcribed student experience does not sit comfortably with me. So rather than to involve the participants in this form of validation, I paraphrased and summarised responses during the interviews, allowing the students to make changes where and when necessary. This felt more like I was ‘validating’ their personal experiences and perceptions. It also formed a ‘reality check’ for me of whether I understood the true nature of what they were telling me. Besides the issue of validation, this method of communication allowed me to enter into a spontaneous discussion with the students and resulted in a reciprocal perception of equality.

My discussions during individual and group supervision have allowed me to view the concept of validity and reliability differently. I don’t consider the research method or student responses as needing validation as much as I need to validate my own choices and



perceptions. I think it is more important for me to provide the reader – and myself – with transparency in the research process. We need to be able to follow my mental and decision-making processes and understand how (my) life experiences impact on all stages of (my) research. I want the reader to rewrite the research in their reading and for the content to resonate at a personal level. I feel that only when this happens will I have produced something worthwhile – something that it is reliable and valid in its intersubjectivity.

All the interviews were conducted in Dutch and audio taped. I simultaneously transcribed and translated the focus interviews and the first of the individual interviews into English. This was primarily to provide an English transcript for my supervisors in order to reflect on my interview techniques during supervision. Issues relating to interpretation when interviews are translated by the researcher have been discussed in the literature (Temple & Young, 2004). Temple & Young also address the issue that translation entails more than accurate use of correct words; as such, I did not translate the interviews verbatim, but in (colloquial) context.

Together with a colleague, I established a system of control to establish accuracy in translation. As my native language is English (but I lived in The Netherlands for 24 years and am fluent in Dutch), I transcribed and translated the interviews. Then an independent, academic, nursing colleague (whose native language is Dutch and who has lived in England for 25 years and is fluent in English) agreed to randomly check the interviews to verify the accuracy of context, transcription and translation. This worked well for the translated interviews.

After the double-check of my interview technique and understanding of (colloquial) Dutch, and the experience of analysing the interviews using the paper texts, I decided to use the audio taped interviews more intensely as I felt alienated from the students when confronted by the texts. Listening to their voices on recording recreated the contextuality of the interview which ultimately, I felt, benefited the quality of my analysis (Halcomb & Davidson, 2006; Poland, 2003).

Bruner (1996: 18) sheds a different angle of light on the issue of translating the interviews by suggesting that ‘thought is shaped by the language in which it is formulated and/or expressed’. This substantiated my decision not to translate the interviews verbatim. However, in presenting the case studies I have included translated quotations. Sometimes the texts are a literal translation and at other times I use colloquial language mirroring that used by the participants. My decision to be freer with the use of language was difficult and I was

relieved to find publications on the dilemma relating to the rigours of presenting qualitative research findings (Rose & Webb, 1998; Sandelowski, 1993):

... we can soften our notion of rigor to include the playfulness, soulfulness, imagination, and technique we associate with more artistic endeavours, or we can harden it by the uncritical application of rules (Sandelowski, 1993).

What I have attempted to do in my work is to provide information and insight within the context of individuality, respecting each of the participants and myself in the process, and so I have opted for the former, 'softer' approach as suggested by Sandelowski in the quotation above.

### **Collecting data from the students**

Roper & Shapira (2000) discuss data collection and method triangulation in longitudinal research as consisting of participant observation, formal and informal interviews and analysis of documentation and reports. Pollner & Emerson (in Atkinson et al., 2001) warn of the dangers of socially acceptable answers during interviews and recommend direct observation of participants. Pollner & Emerson go on to cite Garfinkel (1967) as 'making the familiar strange' in order to observe the reactions. Within the confines of this study it is impossible that I am able to observe students directly in the actual ward setting. This can be seen as being one of the weaknesses of my study. However, I use interview techniques requiring the student to engage and interact. This can be seen as creating a situation between student and researcher which is similar to what occurs in the clinical setting. Neuman (2003: 367) discusses 'violating a tacit social norm' to elicit a strong response from the respondent. In applying what Neuman (2003) calls 'breaching' during the interview process, I attempt to challenge behaviour in the students which can then be discussed further during the interview.

At the outset of the study I asked the participants to join one of three focus interview groups planned on days that would be convenient for most of them. There were three participants in each group. After the initial focus interview, individual interviews were planned to be held bi-monthly, but due to practical constraints and time investment by the participants I decided to conduct individual interviews every six to eight months, though in reality there was one gap of 11–12 months. In retrospect, this didn't present a problem.



All the interviews lasted approximately one hour and were open and largely unstructured, allowing the students to share issues of priority without prompts from me. Roughly midway through the interview I would refer to issues from the previous interview(s) and challenge similarities and differences contained in the content of the current interview. In this way I attempted to create a situation in which 'one in authority' (the researcher/me) in some way questioned the perceptions of the student (the participant), resulting in a social response that we could then discuss in more detail. I saw this as being the nearest I could get to 'breeching' (Neuman, 2003), in which tacit rules from practice could be illustrated. On the one hand, eliciting a response from the student in this way could verify or refute descriptions of coping with 'authority' in the clinical setting. On the other, it could highlight and clarify possible changes in the student's responses and behaviour in the preceding period which we could then discuss in more detail.

Initially I collected all the written assignments and reports from the students, but elected not to read the documentation until such time as I had analysed the data in its longitudinal totality. I did not want to be tempted to discuss issues important to me rather than allowing the students to prioritise issues they felt were important.

The documentation provided by the students includes a description of their care philosophy written by the student at the start of the educational programme; critical incidents mandatory to the educational programme; case studies relating to patient care which generally also include large sections of reflective narrative; and reflections on their learning process produced by the participant each time they move to another placement (usually twice a year – placements are between 20 and 30 weeks on a unit or ward). Owing to time constraints, and as not all products written by the participants may be directly relevant to the research, I chose not to translate any of the documentation but opted to use appropriate pieces if and when necessary. Besides, I feel that any translation on my part may well compromise the originality of the student's work.

At the beginning of each interview I obtained consent from the students to reinforce the signed, informed consent I'd already obtained. I took notes to serve as reminders during the interview in the event of having to ask further questions and these included issues pertaining to content, process and possible non-verbal cues (Holloway & Freshwater, 2007).



As I have already indicated, interviews are unstructured and directed at uncovering (what the students consider to be) important issues or incidents related to the nursing programme experienced during the months since the previous meeting. I opened each interview with the question: 'What are the most important situations you've experienced since our last meeting?' I felt that the order (positive or negative) in which the participant discussed situations could indicate their priority – I checked my observations and interpretations with the student during the interview.

I initially went to the wards where the students were working to interview them so that they didn't have to leave their workplace. I soon didn't feel comfortable with this arrangement as I felt it compromised their anonymity and, having worked in the organisation for ten years and being well-known in all the departments, I felt my role as a researcher was in jeopardy. I addressed this by organising a space away from the ward where the students could come without being exposed to social control and peer pressure on the ward. This improved the idea of participant anonymity and benefited the quality of the interview due to the peace and space we were able to create. Wherever possible, the interviews were planned at the end of the day, but during work time – this could, however, vary depending on the preference of the participant.

Potential power issues that may have become problematic between me, as the researcher, and the students were resolved due to my leaving the organisation to work in the UK within a year of commencing my study. Henceforth I had no further influence on their academic or clinical achievements, which placed me in a more neutral position.

The informal nature of my interaction with the students (apparent from the transcribed interviews) suggests that they feel relaxed enough to share whatever they need to in a positive and a negative sense.

The students are comfortable with my taping the interviews and summarising and checking what they say during the interview as a form of verification. They do not have the desire to read the transcripts. During some interviews I refer to the transcriptions or notes I have with me and sometimes read verbatim excerpts. To date this has not resulted in the participants' denying anything they had said during previous meetings.

I ultimately met with each of the participants five times in the course of their four-year programme. My initial meeting with them took place during the orientation stage of their programme, when they formed part of the full

cohort of students who started with the programme (see appendix 2). The first meeting in terms of official data collection for my research was a focus interview, at the start of their second year of study. Thereafter the interviews were one-on-one at the request of the students themselves.

During each interview I asked them to share what they felt were important occurrences since we'd last spoken – this normally took up the first half of the hour-long meeting. During the second half of the interview I referred back to previous interviews and asked the student to reflect on how they viewed incidents they'd previously shared if they hadn't already done so. I also linked situations and issues between the interviews and asked the student (a) whether they recognised the themes I identified – such as boundaries, ethical dilemmas and adaptation to ward cultures and (b) how they viewed their development with regard to the themes as they progressed with the nursing programme and accumulated more experience.

In the final interview – around the time of their submitting the final assignment for the programme – I presented each participant with a blank page and coloured pencils and asked them to draw a picture symbolising their journey through the four years of the programme. After completing the drawing, the participants explained the symbolism contained in their pictures. Where appropriate, I referred to previous interviews and asked where, if and how some of the situations discussed in previous interviews were represented in the drawings.

Of the five students taking part in the study, three participants – Olga, Linda and Isa - were at the stage of submitting their final assignment one participant – Marijke - had been granted a three-month extension due to ill health, and one participant – Annemieke - had stopped 15 months into the programme, but had agreed to have annual interviews with me to reflect back on her experience.

Marijke and I decided that we would conduct the final interview at the same time as those students graduating at the end of the programme, but that she would submit her final assignment three months later so that I would have the a complete set of documentation. This is in fact what happened.

### **Analysis of the student experience**

My initial thinking with the data analysis was to analyse each interview chronologically and build each student's story in this way, to make continual comparisons between the students



and allow the findings to emerge cumulatively. In reality this turned out to be impossible and contrary to the idea of a retrospective, longitudinal study. Besides, as I became more engrossed in the study I realised that I was dealing with five individual case studies, each one personal and specific.

In trying to get to grips with the data I realised that I was relying on my past research experience in using a matrix to assist analysis. I had anticipated that by reading the transcribed interviews, any themes and context units that emerged could be placed in a matrix illustrating the main points of focus. These focus points could then be used to investigate ways in which the participants deal with the influences. I had intended, initially, to discuss themes within the theoretical framework incorporating a more detailed literature discussion related to the findings. This process would be ongoing throughout the study.

In my initial attempts at coding the data – Charmaz (2000, in Denzin & Lincoln) discusses the importance of line-by-line coding which is used by the researcher to sharpen their use of ‘sensitising concepts’ – I found that I was being alienated from the students and was de-contextualising their stories. I coded the transcribed interviews using a line-by-line system in which the year, month, initial of student concerned and line is indicated: (04-O49 = 2004, Olga, line 49). The later interviews which I didn’t transcribe I coded using a system indicating the year, initial of student concerned and minute/second indicator: (05-O3.10 = 2005, Olga, 3 minutes, 10 seconds into the interview).

The data from each student interview needs to be considered as an independent unit of knowledge. Each interview is reviewed as a whole and related to prior data collected. I use the documentation and reports provided by the students to ascertain similarities and differences between the issues they choose to write about and what we discussed in the interviews. Only as part of the conclusion shall I discuss commonalities between the students’ process, experiences and perceptions.

I believe that exploring the way students negotiate their way through nursing and ward cultures is in keeping with the ethno-methodological approach, the focus being the student’s learning process. My research therefore focuses on exploring the longitudinal learning process the students undergo in which the analysis is done retrospectively from the end point to the beginning. In this way I feel that the student’s process can be documented and expect that elements of cause and effect can be established. Freshwater (in Holloway & Freshwater, 2007) doubts that cause and effect can be distilled from narrative due to the links not being explicit and difficult to discuss. In part I agree, but I feel that by identifying behavioural themes over a long period of time I should be able to



identify subsequent responses to similar situations that could be linked to an important situation or incident. In an attempt to address this issue, when conducting the interviews, I have continually used elements of constant comparison between current and previous meetings in order to place the student experience within an individual, continual process rather than primarily attempting to use the technique to build a theory based on the students' combined experience as in a grounded theory approach.

Through my reflections I have identified specific, but continually changing, ways of seeing the data and have spent much reflective time contextualising my thoughts and emotions to underpin my ideas. Group and individual supervision have helped me identify, refine and specify these thought processes.

With this experience and insight I embarked on analysing the students' stories.

## **SECTION FIVE**

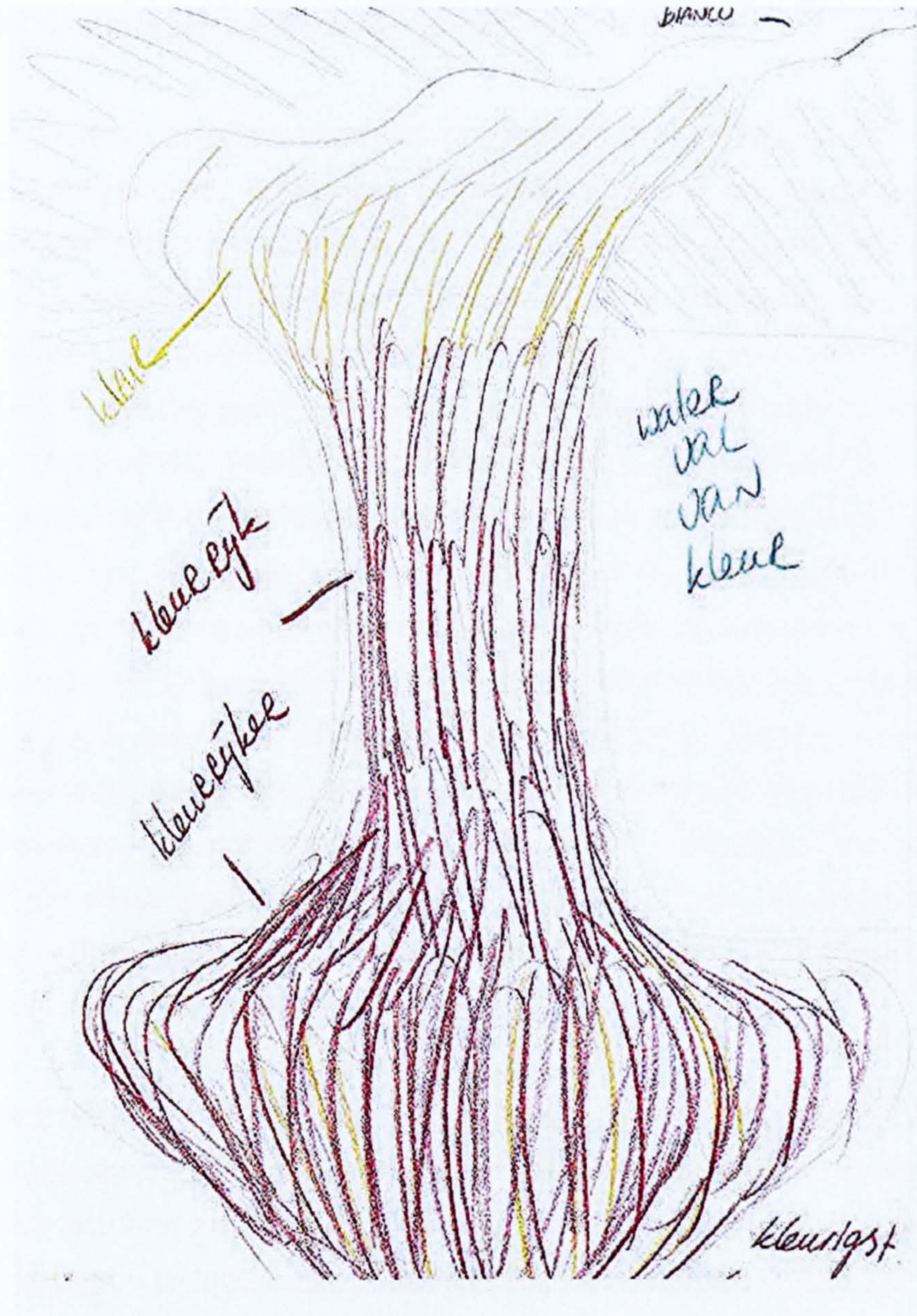
**Olga's 'waterfall of colour' ... so sad and beautiful at the same  
time**



## Olga's 'waterfall of colour' ... so sad and beautiful at the same time

June 2006:

'The colours have painted my palette through the diversity of the people I've come into contact with, my increased involvement in the profession and the increased responsibility I'm able to take.' (06-02.28).



### Olga's 'waterfall of colour'

In Olga's words, her waterfall symbolises a pale, blank start prior to the nursing programme. There is yellow turbulence in the 'run up point' of the first year of study in which 'my blood bubbled at everything I'd seen – it was no specific situation, rather the total and the realisation that this is for me' (06-013.00ff) just before she went 'over the edge' of the first year of the



programme. The orange of the second year was symbolic of her 'fall over the edge' in which Olga indicates 'I increased my realisation where my boundaries were. Where I kept coming up against' (06-O13.00ff). The red excitement of the third year was one of 'free fall' in which Olga 'realised what I really found important in care – what I wanted to carry out' (06-O13.00ff). And in the vibrancy and turbulence of the end of the programme's fourth year 'I realised that my balance between professional and personal was well integrated' (06-O13.00ff) as the river redefines its course and flows further.

In Olga's drawing, she indicates that the colours are important. The pale/grey of life pre-programme: 'There was a drawing (a figure) on the canvas to start with, but it became increasingly fuller' (06-O7.00). Then came the first year of the programme which is yellow: 'Warm colours – my colours are red, orange, yellow – friendly, happy colours' (06-O8.52). The second year of the programme is symbolised by orange: 'Colours became warmer during the course of the training' (06-O9.25). The red third year, not the red of danger, but 'Exciting with the free fall of water – you don't know where you'll end' (06-O9.58). The final year of yellow/red/orange: 'But once you've reached the end it's an oasis of peace and clarity 'we're here all together – it's good' (06-O9.60ff). The unpredictable – that's what I like about the profession. It stays exciting and you can move in different directions, learning situations – you always learn every day (I think) always in movement (06-O10.23). Olga goes on to say: ' (The) further course of the river – dynamic – the stream needs to get more colourful and fuller. I don't know (how the stream will progress) – the uncertainty is important for me – I don't plan ahead. I leave my options open'. (06-O35.20).

Experience has been an important issue and Olga is clear that she had a more or less blank start to the nursing programme. She didn't know what she would experience and had an open attitude to everything. In the first year she was curious and open to influences. She thought the profession would fit with her personality and wanted to absorb all experiences and the learning process – in her own words: 'a sponge' (06-O2.28ff ).

By the second year Olga introduces her idea of colour: 'I am more colourful due to the variety of people, influences and especially the behaviours - The people formed me and gave me colour. I am colourful due to my personal growth, my role as a nurse, I'm more assertive and what I believe in.'



The third year and Olga maintains: 'I'm more independent – a real professional. I have more knowledge at my disposal.'

However, the further course of the river still needs to be defined: 'I can only attain this after many years experience – I haven't achieved this level yet.'

In discussing the drawing Olga reflects on her journey: 'I'm aware that I am the one who must do it – I can make decisions, with advice from others, but you need to do it yourself – I have become more aware of this' (06-O36.30). 'I have awareness due to discussions with others (interviews, mother, partner, friends) I have become aware as to where I stand in relation to these things' (06-O37.29). 'Also (awareness) when you reflect on your passage in the past four years – that you pass through different phases but it has to do with one person – yourself' (06-O37.56). 'You must reach a balance with all the things you experience and feel (conscious and unconscious) in the phases of the waterfall' (06-O38.19). Within the context of study supervision: 'I'm disappointed that I'm not more aware of these bumps (barriers) and confront them – this leads to slight panic' (06-O42.24).

In Olga's words and from her perception in the final stages of the nursing programme it was an, essentially, positive experience. The issues she discussed during interviews in the previous three years were not spontaneously given a specific place in the journey she had.

I questioned Olga during the final interview that although different situations had had an impact on her they were not mentioned in the stream/waterfall (06-O30.50ff). Olga's answer was: 'there are so many important situations and not all situations are discussed during the interviews or reflection'.

Olga's answer resonated with me while listening to Arthur Frank's keynote address (2006), during a qualitative research conference, in which he discussed the concept of plots and 'emplotment' in a story or narrative. The teller filters aspects of their story in order to make sense of it and provide censure according to priority and context; the listener – in their turn – filters the narrative they hear and provides it with another plot which relates to their personal (life) story. Insight relating to active telling and listening answers my surprise at Olga not including the, to my mind, startling revelations she'd shared during the interviews I'd conducted with her. It seems appropriate now, in an attempt to plot how Olga has made sense of her reality and reached this stage of personal



and professional integration, that I should present the information I gathered in the course of the dialogue we shared on her journey.

December 2003:

At the time of the focus interview in December 2003, Olga's first placement was on Ward B, during which she was 'thrown into at the deep end' (03-O10/O13-3), she was being allocated freshly operated patients to nurse independently within the first week and soon after had four patients allocated to her care (03-O10/O13). She articulated that she thought this was normal practice and a level of care she should be able to cope with seeing that these patients were being allocated to her by the ward staff (03-O12-4). She explained feeling stressed that she wasn't able to meet the expectations of her registered colleagues (03-O10-3). She maintained at the time: 'in order to prove yourself you go over your personal boundaries' (03-O3).

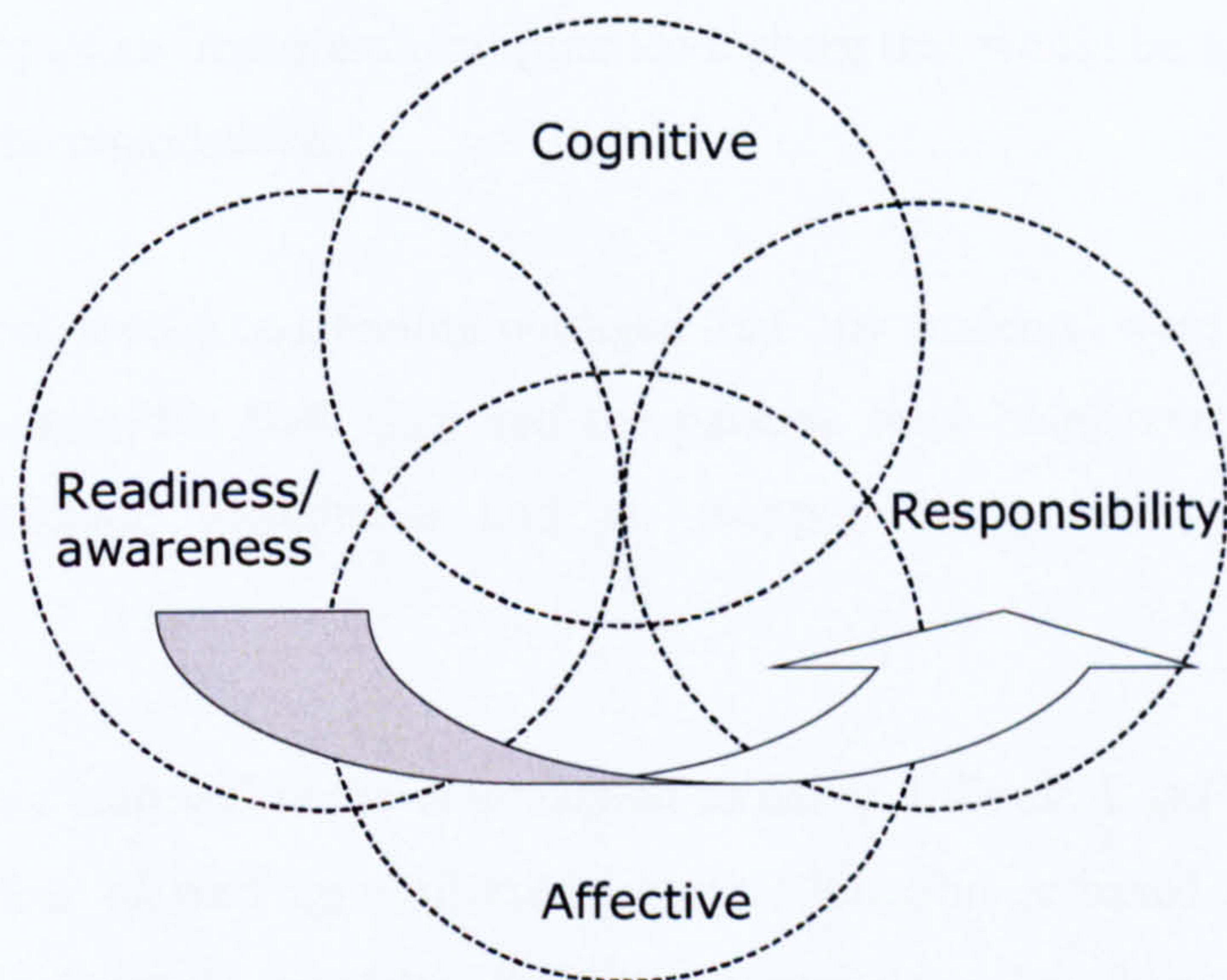
It would appear, at this stage, that Olga was so aware of perceived ward expectations and her emotional need to be accepted as part of the team that she was being driven to take responsibility outside her capabilities. At the time she explained: 'I really had problems with boundaries – I didn't know what was expected of me' (03-O3). In the final interview Olga talks of this feeling as being in a state of turbulence and being 'a sponge absorbing everything' (03-2.28ff). In a personal reflection during the focus interview Olga shared: 'you don't realise you're drowning/not coping' (03-O17).

Olga's learning in practice and in theory at the time of the focus interview seemed to take place in two separate locations. Even though Olga had an allocated practice mentor, there were planned reflective sessions and a clinical tutor was attached to the unit, she indicated that: 'school is where you learn/ward is where you work.' Problems with planning and knowledge and skills, i.e. learning objectives are not learnable on the ward due to the pressure of work (03-O20-6). Practice-based learning was 'reflection after/prior to action (with the mentor) rather than "in action" – there's no time (even with a clinical tutor on the ward)' (03-O20-11).

In figure 5.1 I've represented Olga's learning process (December 2003) in terms of Castillo's (1974) model. Owing to her awareness and readiness to learn, she appears to be led by the affective domain to take responsibility for work often too complex for her experience and status. Cognition, although present, seems divorced from the practice setting. Reflection with practice mentors seems aimed at being able to take the responsibility she perceives to



have been allocated by the ward, rather than investigating boundaries and realistic expectations. The unrealistic expectations from the ward resulted in Olga doubting her own capabilities and ability to manage time (03-O10-5). She maintained at the time that the allocation of patients led to increased responsibility and Olga accepted this as she 'thought she could handle it'. During the focus interview Olga maintained she 'did not feel happy at work and was stressed – was walking on eggs' (03-O10-3).



*Figure 5.1: Olga's learning process (December 2003) illustrated in terms of Castillo's (1974) model*

Another interesting theme that emerged during the initial focus interview was the fact that Olga was aware that 'routined nursing staff and doctors don't stick to protocol guidelines and can't base their actions on an evidence base' (03-O24-7). When questioned about this during the interview Olga maintained: 'now you stick to the rules, but with experience we'll rise above them too' (03-O28-7). However, during the same discussion Olga maintained: 'when we're further along with our training and stand stronger we can base our ideas and arguments on evidence and I can be more assertive and refer to the protocol. She maintained that later in her training she would develop the skill to be more persuasive with others (03-O36-9).

This discussion on whether students maintain standards according to protocols and guidelines was an ethical issue for me and I challenged Olga on her position and action in conforming to the ward culture and not adhering to protocols and guidelines. Her answer was that she disregarded some guidelines in order to conform to the culture on the ward



‘but this would depend on how serious it was – any discomfort to the patient would be a reason not to conform to the ward culture’ (03-O31-8).

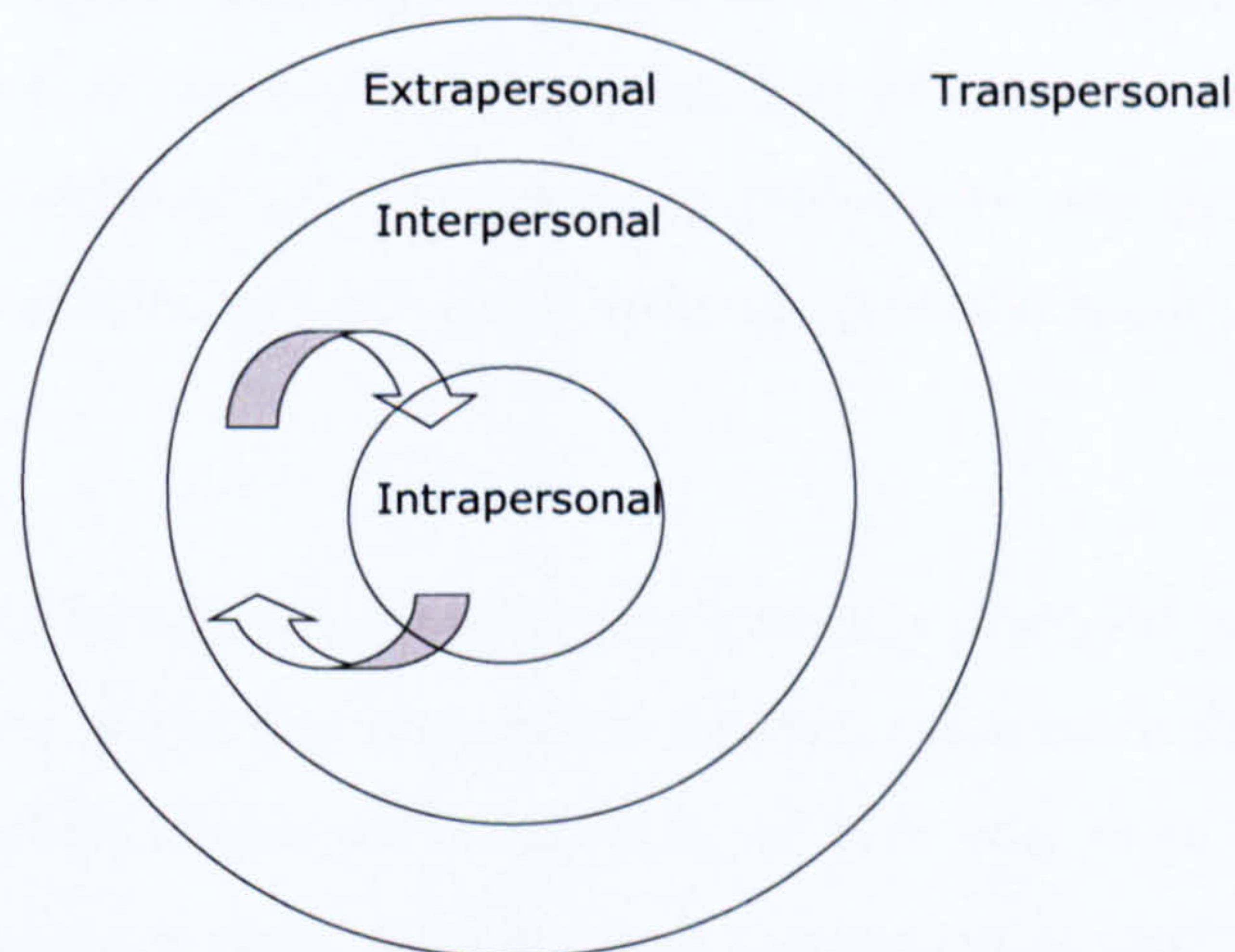
This discussion with the focus group of students had a marked effect on me as I felt that I was in a catch-22 position. To take this further within an organisation I no longer worked in would compromise the confidentiality of the students and I would need to lodge an official complaint with the organisation. On the other hand, I was – based on acknowledgement of the situation by the other students in the focus group – probably uncovering the tip of an unprofessional practice iceberg that would be affecting students and staff across the organisation.

At a more personal level I was feeling outraged that ‘my students’ were being socialised into bad practice and that both they and the patients were being exposed to risk and danger by inadequate mentorship and an irresponsible patient allocation/student experience ratio.

I perceived my position within the organisation as being difficult. I had been a respected and valued member of staff up until the moment I left (this is based on the extensive organisation-wide farewell reception that was organised – the format of which was officially reserved for senior management-level staff). However, since leaving there had been a change in educational direction and the concept of emancipatory reflective practice was being systematically replaced by a more medical model of evidence-based practice and clinical pathways. The clinical education department was involved in what ultimately became a very messy political coup. Reflective sessions were being more structured, strict templates imposed for critical incident analysis and emancipatory activities were being discouraged. At that stage I didn’t know how to deal with the situation appropriately and so chose to introduce emancipatory and empowering reflective dialogue during the interviews with the students. ‘My girls,’ as Jean Brodie (Spark, 1961) would have said, ‘would be a force to be reckoned with.’

According to DeMeulle & D’Emidio-Caston (2003), the intrapersonal domain includes emotions, personal beliefs, creativity, values and thoughts and the interpersonal domain is home to the aspects of group leadership, group dynamics and interpersonal communication. Viewing Olga’s learning at the time of the focus interview in December 2003 through the lens of the DeMeulle & D’Emidio-Caston (2003) framework (figure 5.2) it appears that the focus of learning was occurring between the inter- and intrapersonal domains.





*Figure 5.2: Olga's learning process (December 2003), illustrated in terms of the DeMeulle & D'Emidio-Caston (2003) model*

Olga's emotions and personal beliefs in the situation of December 2003 seem characterised by the fact that she reached a point where she became aware that she wasn't coping and thought it 'was crazy' (03-O12-3). Her learning as to what her boundaries could/should have been came through 'hearing from fellow students and registered nurses on the ward as to what was expected of them' (03-O12-3) and it was 'the reflections and discussions in class' that caused Olga to question her workload (03-O12-3).

To my way of thinking Olga had at this stage, as a first-year student, a strong dependence and trust on the ward leadership (which implies all staff on the ward and not only those in official management and leadership positions). In fact, Olga implied numerous times during the group interview that she was 'totally' dependent on what others in the team thought she should do/be able to do (03-O3/O10/O12).

I find it an interesting observation that although Olga expressed this 'total' dependence on the ward team, she also seemed uncertain that they were clear in their expectations: 'the ward understanding/expectations of what a student can do are unclear' (03-O12-5) and 'it's difficult to set boundaries due to the unknown expectations of the ward staff' (03-O3-1). Olga also had an element of anger towards the curriculum criteria: 'there are no clear rules as to what the student should be able to do' (03-O12-5).



The concept of clarity as to what a student is expected to do in each year of their programme had been a topic of ongoing discussion within the hospital. From a reflective practice perspective we had been hesitant to provide lists of tasks and activities for each year of the nursing programme as the underlying philosophy was that nurses should access their ability to undertake patient-related tasks and procedures within the context of a specific patient's care.

Anecdotally, the issue of having task lists per year generally provided greater discussion on surgical wards where production and patient turnover were more the focus, than in medical departments where contextual complexity of care was more the norm. Task orientation was so ingrained in some surgical wards that registered staff would argue that students were not able to achieve learning goals related to chronic illness and even when surgical patients were identified as having diabetes, COPD, arthritis or long-term cardiological illness, they would argue that patients were not admitted for those diagnoses and so chronic illness was not in the foreground.

The situation exemplified by Olga's discussion was precisely the concept behind the clinical curriculum in which students were supported to challenge the ward's way of working, status quo and decision-making. We felt, at the time, that too many (student and registered) nurses were blindly carrying out tasks without adequately analysing the complexity of the situation and therefore were placing both the patient and themselves at risk. We also felt that by allowing the student to own the uncertainty regarding their boundaries and support them to reflect 'in action' whether they had the expertise to carry out the procedure before them, they would be learning a skill that would (a) stand them in good stead for the rest of their career and (b) start to change nursing practice.

Perhaps this ideal to change practice via the student as a change agent was a bridge too far at the time and it does have ethical implications for the patients, students and ward staff. However, we did feel that by providing clinical educators for each ward, a three-day mentorship training as a rolling programme for the registered staff, clinical lessons on the curriculum and underlying philosophy on all the wards and bi-weekly reflective sessions for each cohort of students, we were not sending the students out to fend for themselves and that the support was adequate.

I believe that the issue Olga was confronting in December 2003 was not only related to the mentorship knowledge and skills of the registered staff on the ward, but also has to do with the culture and group dynamics.



Quoting Olga in the focus interview at the time, I would suggest that it illustrates conflicting values within the ward culture. Olga suggests four perspectives from her second-year student nurse status:

- (a) her perception of being thrown in the deep end and learning by trial and error: 'to learn, you must simply DO things – if you get stuck you can ask' (03-O21-11), but also that she found it difficult to express the fact that she wasn't coping with the allocated patient load (03-O12-3);
- (b) learning from role modelling and what she sees in the work environment: 'pressure of work pulls you over your boundaries' (03-O1-1) and 'the busyness of the ward leads you not to ask questions or set boundaries but to try to be like the others' (03-O20-1);
- (c) responsibility placed formally on the student's shoulders – Olga was given feedback from the ward 'to discuss abilities openly and set boundaries' (03-O16-4), but also informally through feedback from fellow-students and newly qualified staff on the ward 'to ring the alarm bell if it gets too much';
- (d) the perceived ward culture and group dynamic: 'it takes time to recognise things that happen on the ward (politics) and you need to feel more at ease before you can actually recognise them' (03-O34-7) and 'when the ward organisation allocated patients to students as the norm, it's then difficult to question the validity of the ward's decisions' (03-O17-4).

Although Olga was encouraged to set boundaries and be aware of her abilities, she was also exposed to a strong sense of role modelling in which, apparently, independent work in isolation of colleagues appeared to be the norm. Within this complex ward and learning situation Olga was creative and developed methods of learning from and through the situation. Although learning through reflection-in-action was not an option, talking to a variety of people seemed to provide the insight Olga needed: '(retrospective) reflection with mentor, family or partner provide the biggest learning curve' (03-O23-11), 'I talk informally with the team, mentor and educator about my boundaries – it provides insight' (03-O3-1), 'I was "taught" professional behaviours by colleagues and at school – it gives a taste of what people expect' (03-O9-3).

In the context of the focus group discussion in Olga's second year of the programme she was clearly taking responsibility for the situation and was prepared to own her part in the situation: through the system of allocated



patients she was confronted with time-limits and planning problems (03-O10/O19). This had, in part, to do with the fact that Olga was allocated her 'own' patients, but was also expected to help colleagues when necessary: 'important, but difficult to find a balance between your own boundaries, your own work and team work' (03-O1-1). She summarised this part of the discussion by saying: 'I need structure with regard to my boundaries' (03-O3-1).

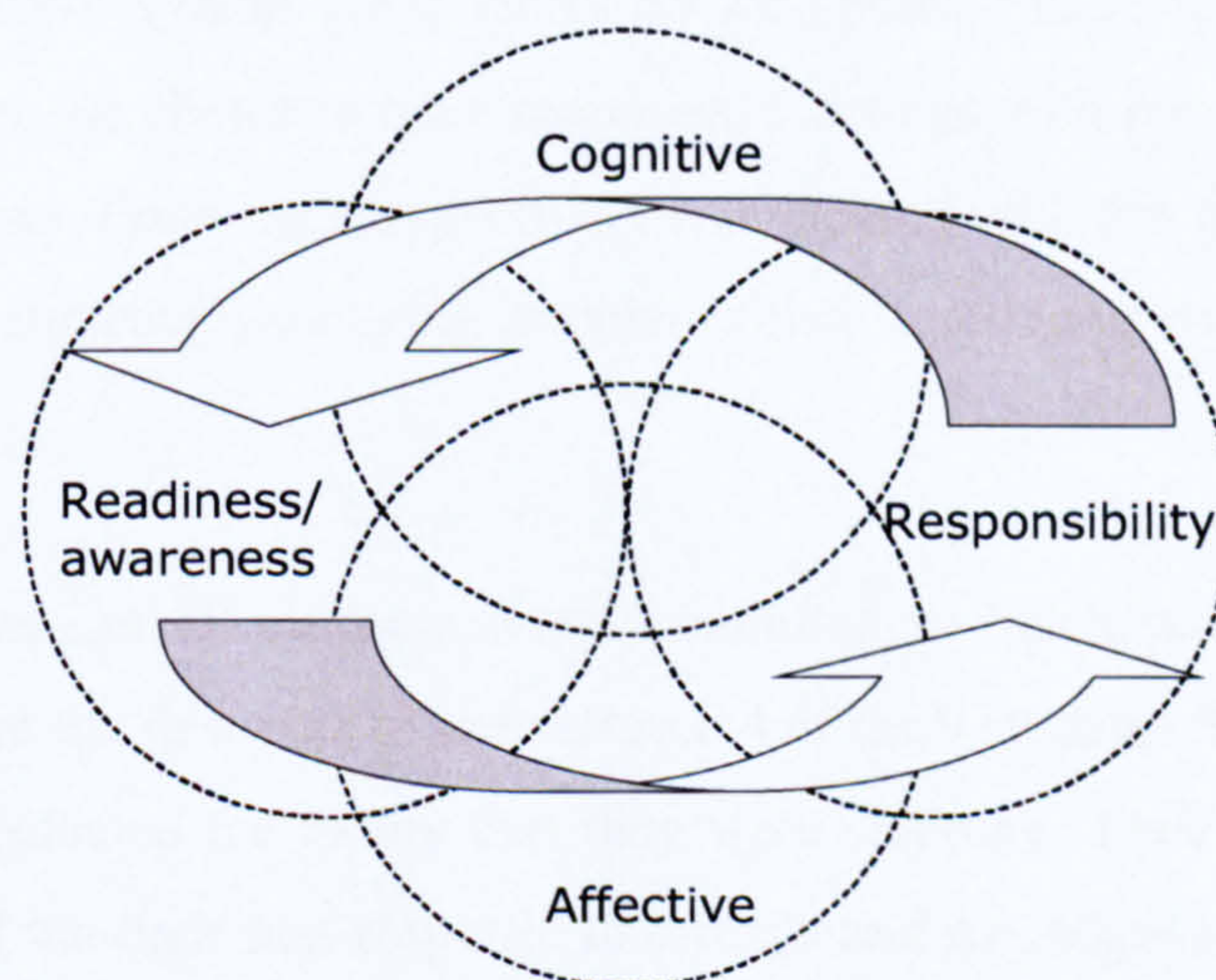
Boundaries were very much part of this first interview with Olga in her second year. It is interesting to hear at the end of her fourth year how she reflects on learning from the situations: 'You're constantly confronted by things', 'Sometimes I skirt the bumps (barriers) and other times I challenge them. Even after you skirt the bumps (barriers), you are often re-confronted by them so eventually you have to challenge them', 'It's important if people confront you with the bumps (barriers) – you grow and develop from it', 'Sometimes I'm not aware of skirting the bump (barrier) – sometimes you need to confront similar situations in order to recognise them as barriers' (06-O16.06ff), 'The bumps (barriers) is the confrontation by colleagues and others of your behaviour' (06-O25.31).

Confrontation with and learning from her behaviour was another situation discussed during Olga's first focus interview. In her story Olga tells of how she'd been very busy getting things done for her patients and how she'd done 'everything' for one patient with whom she had good contact, but had forgotten 'one small thing' (she didn't elaborate as to what this 'small thing' was). The patient had become very angry with Olga and had reacted in a way that Olga found unacceptable and unfair based on her expectation 'that a patient should be grateful even if you forget things' (03-O5-2). Olga's way of dealing with the situation was to confront the patient with his behaviour and then walk away and ignore the patient (by not greeting him at the end of her duty as she normally did) (03-O5-2). This situation resulted in Olga having feelings of guilt and reflecting on her reaction as being 'childish' and 'unprofessional' (03-O7-2ff). During the discussion Olga was not able to say how or why she felt this, but explained this more in terms of her intrinsic value system and her respect for the other. This situation would, in time, prove a valuable moment of reflection.



June 2004:

When I next spoke to Olga in June 2004, she had moved to her next placement on Ward C and was on a 10-week external placement in a chronic mental health independent living group. This exposure to an external placement was proving to be a strong impulse in her learning process and enabled her to move away from the dominant affective approach that was apparent during the previous interview. She now appeared to be integrating cognition in preparation for the responsibility she expected to take. Olga was aware that she had previously 'stared blindly' at the learning objectives framework and that she needed the mental health placement to obtain objectivity and work with the plan as intended (04-O33-1). Olga discussed how she used books, the Internet and colleagues across disciplines in the work environment to find the knowledge and facts to complement her experience (04-O6-4/O5-1) – she was aware of a change in how she was in practice: 'you observe things differently, more deeply' (04-O3-1) and 'you analyse more and diagnose more' (04-O3-2).



*Figure 5.3: Olga's learning process (June 2004) illustrated in terms of Castillo's (1974) model*

Figure 5.3 illustrates how, during her first placement, Olga initially channelled her enthusiasm through her emotions to take responsibility for what she felt she needed to do. Now, six months later, she appears to have mobilised actions allowing her to complete the cycle. Based on her feelings of responsibility Olga is more pro-active in seeking the knowledge she needs in order to be ready to take the necessary responsibility. She also seems to have taken the level of learning a step further and is integrating the concept of how



to learn into the equation. She does this from a cognitive perspective: 'I need to understand and learn how to formulate learning objectives' (04-O31/O32), but also from an affective perspective: 'keeping a reflective log empties the mind a bit – provides space' (04-O49).

At this stage Olga also seemed to be linking and critiquing the theory learned in the classroom and what she was learning in the clinical setting. She maintained that: 'the tutor alerts you to thinking ahead and stimulates diagnostic analysis' (04-O5-1), but at the same time she felt that there was 'limited use of theory – I learn more from direct interaction with patients and observing' (04-O36-2). In addition, Olga indicated that she was becoming more aware of the 'need for and importance of reflection and feedback in order to learn' (04-O42/O47/04-O48-3).

I found during this meeting with Olga that she was more open in her discussion and aware of her reflections. This could have been due to the fact that this was a one-on-one interview as opposed to a focus group interview with peers. I had been quite surprised by the students' unanimous choice to have individual meetings with me rather than continue with group interviews. From my perspective, I was pleased with this development too as I felt that not all the students were being as open as they could have been during the initial focus interviews.

My assumption that not all students were committed to being part of the study was confirmed as, within the first year of my research 4 of the 9 students dropped out; none of those 4 actually contacted me to say that they were stopping. Their refusal to continue was communicated via their non-response to e-mails and messages asking them to make appointments – even if to say they did not want to continue with the study. The remaining 5 students were committed and responded promptly to requests for appointments or documents.

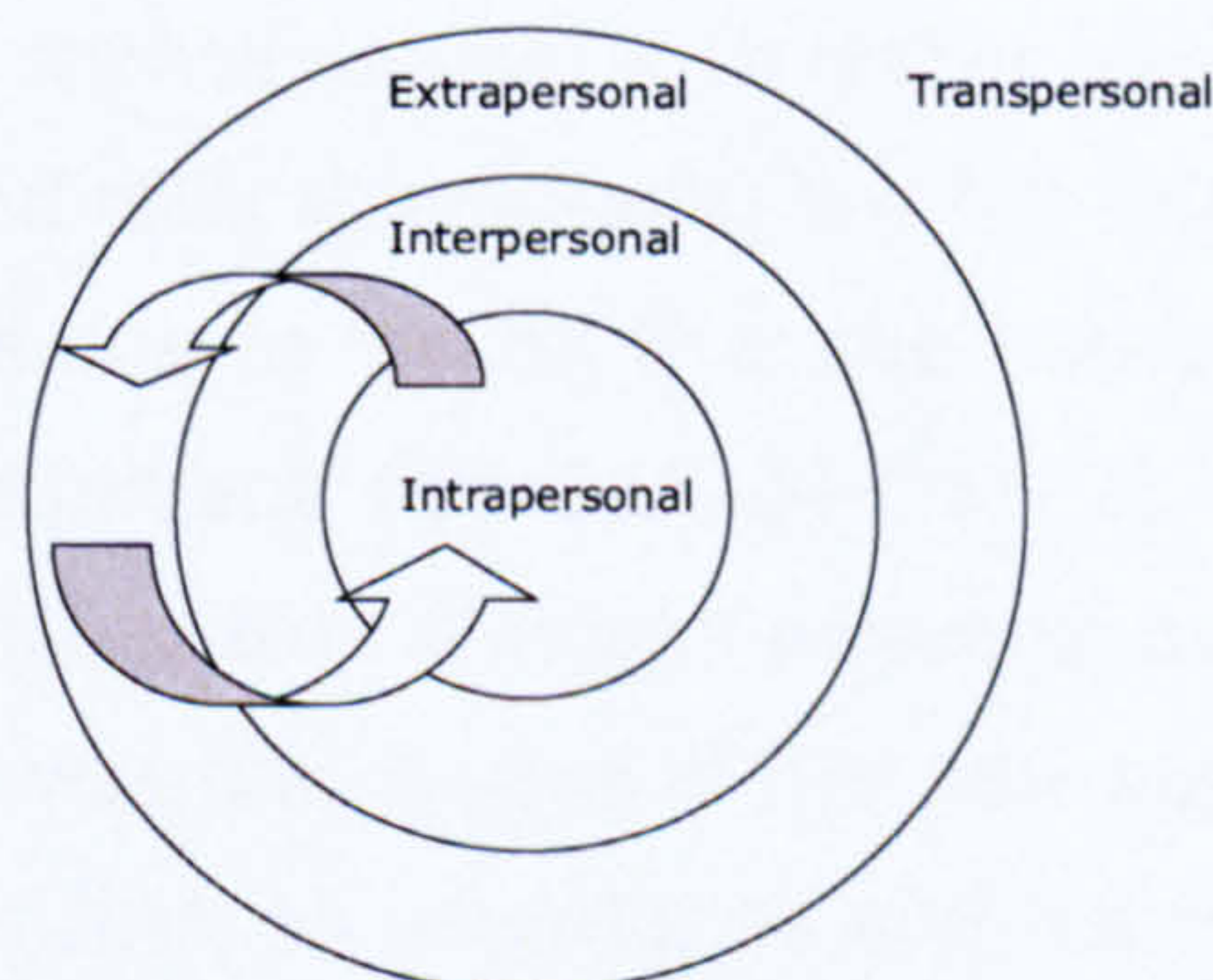
In the model by DeMeulle & D'Emidio-Caston (2003), the extra-personal or social contextual domain includes Societal norms, Politics, Classrooms, Stakeholders, Organisational dynamics, Multi-culturalism, Predefined curriculum, Professional standards and Special needs.

At this stage, and viewed within the context of DeMeulle & D'Emidio-Caston's model (figure 5.4), Olga's learning appeared to be taking place largely in the interaction between the Intrapersonal and Extrapersonal domains.



The learning climate both on the Ward C and in the chronic mental health independent living group provided Olga with a strong contrast to the experience she'd had on Ward B. In her own words, Olga describes Ward C as being 'student friendly and focused on quality rather than quantity'; she goes on to say that this was initially difficult to cope with (04-O26-3). She perceived there to be more clarity regarding the student and mentor roles (04-O26-1) and felt that the 'mentor support allowed for learning to work professionally' (04-O27-2).

During this discussion I was aware of my own issues playing a role with regard to my perceptions of the sensitivity of registered staff to mentoring students on surgical versus medical wards; besides, I was feeling indirectly flattered as the Ward C had been one of the units I was responsible for as a clinical educator prior to my leaving the hospital. Olga, however, caused me to rethink my assumptions and bias when she placed her experience of the two wards into a new perspective for me: 'experience of difficult wards allows you to recognise what you want to learn – you can say what you expect from them' (04-O28-1). I found Olga's attitude and approach to be a mature and professional way of approaching what I perceived to be a system uncondusive to learning in which students learn to adapt rather than learn the essence of care.



*Figure 5.4: Olga's learning process (June 2004) illustrated in terms of the DeMeulle & D'Emidio-Caston (2003) model*

During the previous placement, Olga had had a confrontation with an angry patient whom she first confronted with his behaviour and subsequently ignored as a method of coping with the situation. During our current interview she linked this situation to a new incident in which she had used humour when dealing with a chronic mental health patient. Although she felt that it was appropriate and acceptable to use humour as an intervention as she had a 'good relationship' with this patient (04-O36-2), the interaction resulted in



an angry outburst and the patient feeling that he was not being taken seriously (04-O36/04-O39-1).

In this incident Olga immediately discussed the situation with the patient and apologised for her behaviour which defused the situation and they were able to return to a well-balanced relationship. Olga shared that she was aware of having feelings of powerlessness, disappointment and helplessness related to what she'd experienced the previous year with the similar situation (04-O39-1/04-O42-3) and that the two situations had provided her with new insights into her actions (04-O40-2) – namely: 'you can't read thoughts and therefore need to show patience' (04-O40-2).

There were, at this time, ongoing changes in the educational approach within the hospital and a movement away from sessions of guided reflection. The alternative was to use more structured templates for reflection and critical incident analysis. Olga indicated that she had a problem with it and found it restrictive to work with a predefined framework (04-O33/04-O52-2) and that she found it unhelpful (04-O53). She hadn't, however, discussed it with the educational stakeholders (04-O58/04-O59 -2) and didn't intend discussing it as long as feedback from the educator didn't warrant it – 'no news is good news' (04-O53/04-O54/04-O55 -1). Olga explained that she was aware that she did not communicate spontaneously with either her mentors or tutors regarding assignments and critical incidents, but felt she was able to be spontaneous with patients due to feeling that she had 'the space to be myself on the work floor with the patient' (04-O65/04-O66-2). We discussed her assertiveness and Olga shared that she was aware of being assertive when it came to patient care, but was also aware of her non-assertiveness when it came to her own interests such as boundaries and her learning process (04-O69-2).

Olga's feeling of not being able to communicate 'spontaneously' with educators and mentors threw me into a tailspin as I'd been instrumental in developing a clinical curriculum based on reflective practice and this student's experiences of a – to my mind – paternalistic model and how it was stifling her creativity was contrary to what I'd been attempting to achieve with the new curriculum. I experienced the changes as an attack on my person, damaging to the development of a new generation of students and a lost opportunity to start changing practice from the inside out.



The situation was magnified for me as I still saw myself in some ways as a member of the education team in the hospital and acted the part by using the staff entrance to the hospital, visiting wards where I'd worked and joining my ex-colleagues for lunch and coffee breaks when I was in the hospital to conduct interviews. Spending so much time with the group of ex-colleagues meant that I was included in discussions and was even invited to be at a presentation on the topic of education due to my expertise and role in developing the curriculum. This proved to be a turning point for me as I entered into a passionate debate, became undiplomatic in my criticism of the changes and defended the original underlying principles of the clinical curriculum as I understood them to be. Once I'd started, I couldn't stop myself and effectively took over the discussion.

At the end of the meeting I could have wept with shame, frustration and anger at having allowed myself to be drawn into what I then saw as a dysfunctional relationship. I was aware that I was defending the principles I stood for, but also defending my ex-line manager from – what I saw as – a coup taking place within the team. To add to my discomfort, the person leading what I understood to be the coup was a colleague and friend of many years' standing, which meant that I felt betrayed and isolated. In some ways, the criticism of the curriculum and the methods we'd used to assess students was justified, but I had the feeling that I was being told I was past my sell-by date, which I found exceptionally painful and distressing.

The result of the morning's activities was that, within a couple of hours of the meeting, I had contacted all my ex-colleagues and apologised for my behaviour, relinquished the pass which gave me access to the staff entrance, organised for all future interviews to take place in a meeting room above the hospital chapel away from the wards, made a resolute decision never to visit the wards again or to meet my ex-colleagues for breaks, and left the hospital via the public entrance. It was a painful experience and made me realise that I'd moved on – it also made me aware of my work environment in England – which I shall return to in due course. I felt that all I'd worked for had been a sham and my self-esteem was at a low ebb ...

It did, however, also place my doctoral research in perspective – I became aware that I was conducting the interviews with an ulterior motive and that I was in the position to use the students to meet my own objectives. I found this insight particularly shocking and it resulted in my becoming what I considered to be more research-minded in what I was doing ... probably the nearest I could have come to bracketing my knowledge and emotions. My research became less pressured due to the fact that now I did not feel I had to 'change and steer' the educational programme in the hospital single-handedly and



under cover; but it also meant that I didn't feel comfortable entering the hospital anymore and desperately wanted to close the door, never to return. I was close to discontinuing my research.

Olga's statements relating to her assertiveness when it came to patient care were tinged with a shadow of doubt when she told the story of a patient who had contracted Hepatitis C via a hospital infection. She was angry and disturbed at the fact that the hospital staff 'had failed' in their responsibility to protect the patient (04-07/04-08 -1) and felt acutely responsible for protecting the 'other patients' (04-08-2). She also felt that a huge social injustice had been done to the patient as she wasn't told how she'd come to be infected. Olga felt strongly that it was the nurse's role to open a multi-disciplinary discussion regarding patient vulnerability (04-010/04-012-1). During our discussion on this issue Olga seemed not to have made a conscious decision not to discuss the situation with the team, but also seemed unaware of having boundaries in this regard (04-022/04-024-2).

Olga was most adamant that she wasn't going to let situations slip by without discussing them; but even though the Hepatitis C infection was a serious and ethically charged issue, she had not addressed the situation (04-015/04-016-3). Whereas Olga's task-related boundaries regarding somatic care appeared to have been impinged upon during our previous meeting, I now had a strong feeling that she was having problems in establishing her boundaries with regard to the psychosocial care, but also that she was still feeling intimidated by the ward hierarchy even though she'd shared that it was a more student-friendly climate. Nevertheless, Olga seemed to be discussing the 'injustice' done to the patient from a socio-political perspective rather than her feelings of being overwhelmed by the ward culture. The situation was compounded by her own fear of becoming infected from the patient (04-08-1).

During the interview I chose to confront Olga with her non-assertive decision and we spent some time discussing what it meant to her now that she was aware of how difficult it was to sustain boundaries and had come to realise that situations are not as simple as they're sketched, that one can be aware of a delicate decision without actually discussing it (04-015-1). Olga was defensive in a polite way and indicated that she 'felt less intimidated about discussing other issues, also with other disciplines' (04-046-2), but that situations 'can follow one another so swiftly that they slip through your fingers' (04-015-2).



I was aware that this discussion was entering a potentially difficult interaction, but using my intuition and focusing on verbal and non-verbal communication techniques, we communicated at an intimate level about how Olga saw the situation as a moment of learning.

Olga summed up our discussion by explaining that deep down she was 'aware of letting the situation pass in order to be more aware the next time – and so I also become aware of my boundaries' (04-O24-1) and 'sometimes I need to overstep my boundary in order to recognise it' (04-O24-3). After a few moments of silence she said: 'my most important learning to date has been setting boundaries, but you need to be aware' (04-O43-1) and then concluded with: 'developing assertiveness and increased awareness of the need for assertiveness and being aware always to be mindful of the need for assertiveness – that is what is important to me' (04-O46-1).

I found this to be an emotional moment in the interview, thinking back to the previous discussion we'd had in which Olga had needed permission to 'be' and perceived herself to be 'totally' dependent on her ward colleagues. In the final interview two years later Olga would sum this development up with: 'I increased my realisation where my boundaries were. Where I kept coming up against.' (06-O13.00ff), but would also place her development into a broader context by saying: 'I am colourful due to my personal growth, my role as a nurse, I'm more assertive and about what I believe in.'

As at the end of each interview, I asked Olga whether she had anything else she felt she wanted to share with me. At first she didn't think there was anything extra to add, but then she hesitantly spoke about a 'new' awareness. Olga had identified a thinking/feeling connection as a nurse in a personal nearness/distance relationship to the patient. She explained that she was basing this new-found insight on experiences in her personal life (04-O82-5), but had identified a nearness/distance relationship with a patient (04-O83-4). She explained how she'd discussed the issue of nearness/distance to the patient with her work mentor and her family and had been advised by all parties not to get too close (04-O83-4). I listened as Olga went on to share that she was – for the first time – pondering on a body/soul connection in life (04-O80-4) and a body/soul separation in death (04-O78/04-O80-3).

I asked or added nothing – I figured more would come with time.



April 2005:

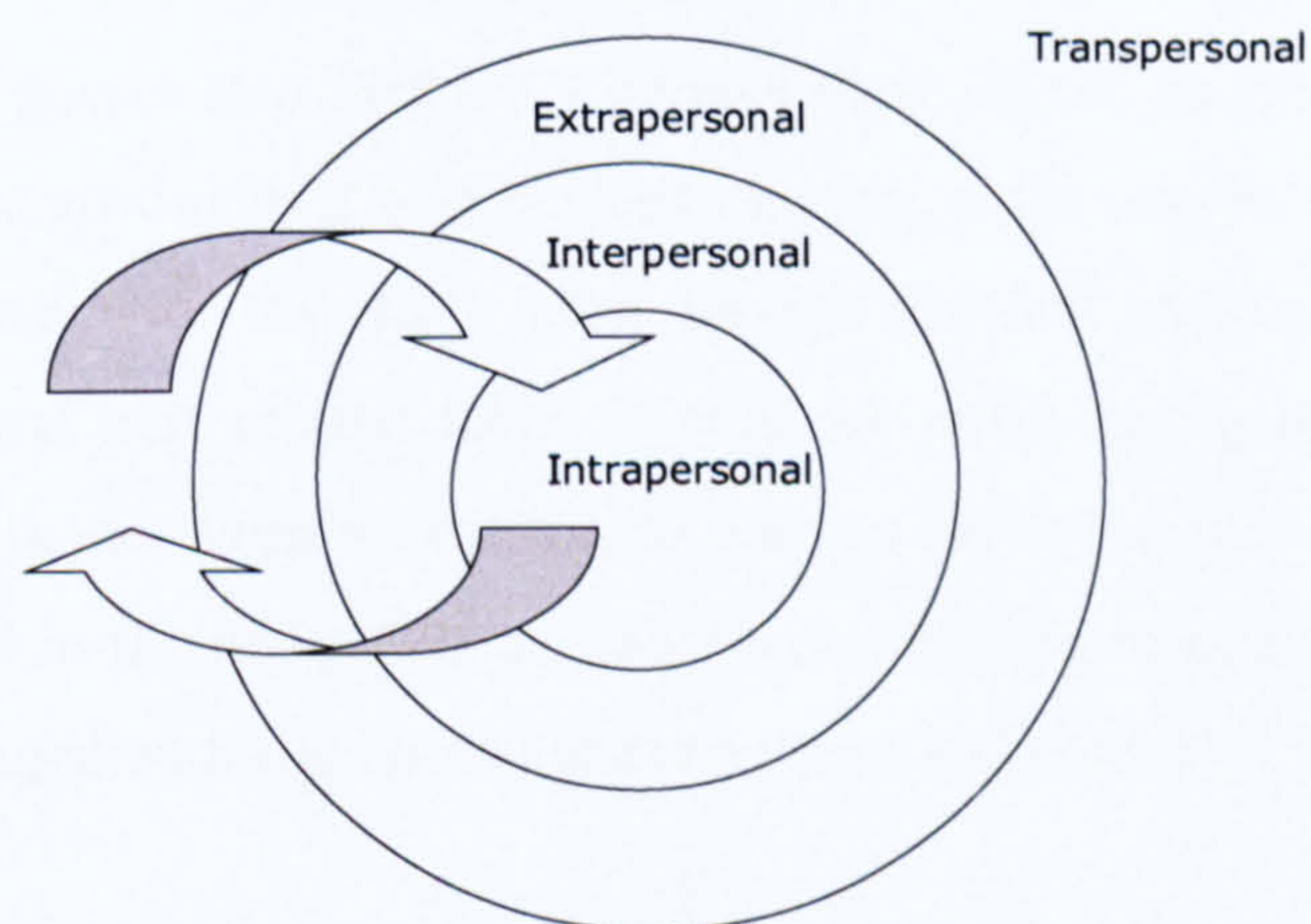
Following the system of alternating surgical and medical placements, Olga was now working on a surgical ward. It was clear from the start of our meeting that Olga was well settled into the ward routine and 'feels linked to the ward as a colleague' (05-O2-1). She is happy with the mentorship and the daily feedback and evaluation she gets: 'it (the evaluation) gives me guidance and a foothold with regard to reactions and attitude' (05-O8-1). Olga appeared to be using peer experiences as an active part of her learning process and admits that 'hearing reflections of others leads to (vicarious) learning in similar situations', but also that she projects the benefits of this learning into future learning situations regarding reactions and attitudes (05-O8-1).

Olga is more confident, which has led 'to improved communication with patients, families, staff and other disciplines' (05-O4-1) and 'I'm aware of my own role and responsibility within the team – I'm far less dependent' (05-O4-1). Olga's confidence has an effect on her learning process and not only does she still seem to be integrating the affective and cognitive domains in the learning cycle, but her confidence is allowing her to create situations in which she is able to benefit the most: 'I need to have space/autonomy to be able to work/learn' (05-O4-1). She is aware that the confidence she has gained is connected to the clarity she now has: 'I'm aware and clear now of the expectations and boundaries regarding the routines and skills (expected of me)' (05-O7-1). Olga's confidence was allowing her new assertiveness and the courage to attempt new things, extending her personal boundaries (05-O9-1).

The boundaries Olga is extending appear to be at a different level from that of tasks and procedures she appeared previously to have been busy with. 'I feel I am able to base good decisions on feelings and intuition' (05-O12-1). She went on to elaborate: 'I see intuition now as being a strength and much less a weakness – I have found love and balance with work' (05-O12-2). 'I find it important to improve the patient's mental and physical health' (05-O12-1). When asked about her 'love' for the nursing profession, Olga maintained that this was not specifically a philosophical reasoning or calling. It was based on her passion, interest and curiosity that she was now able to complement with her experience and increased insight – the variation she perceived in her work is an important aspect of her enthusiasm (05-O9/05-O10/05-O11 – 2).



I perceived Olga as viewing her role from a different perspective than she had done previously. In figure 5.5 I suggest that her development was now occurring through an intrapersonal/transpersonal interaction. Brown, Phillips & Shapiro (1976) include Personal reflections, Philosophical, and Spiritual aspects in the Transpersonal matrix of Yeomans' confluent educational model. Although the Transpersonal domain is not included in the DeMeulle & D'Emidio-Caston (2003) model, I have included it in the model to discuss learning within the nursing context due to the domain-specific focus inherent in a caring philosophy (Nåden & Eriksson, 2002; Watson 1988).



*Figure 5.5: Olga's learning process (April 2005) illustrated in terms of the DeMeulle & D'Emidio-Caston (2003) model*

Olga spoke of how she felt she was developing a 'sixth sense' in her communication – 'I am now able to read people' (05-039-3) and spoke of psychosocial care leading to 'a great feeling of satisfaction' (05-038-2). This was not to the detriment of the expected somatic care: 'I work hard at the physical aspects of my work and really get a buzz when the job is done' (05-037-1). 'I am aware of the focus (on this ward) on somatic rather than the psycho-emotional-spiritual care. I am also aware of the change in my own attitude to this (the importance of a more spiritual approach)' (05-053/05-054-1).

Although Olga was visibly happy with her role and position on the surgical ward, she was not uncritical of her colleagues and ward policy. She perceived power as an issue with regard to controlling patients and their visitors: 'there is power with the staff to determine what happens with patients/visitors' but feels she is not in a position to do anything about it (05-017/05-029/05-030). On the ward there is apparently an issue regarding visiting hours and



Olga feels that 'the value of visiting hours' needs to be discussed in relation to 'flexibility within the team' and again feels she is not able to do anything about it (05-O29/05-O30-1).

I find it interesting that in the course of our discussion Olga indicated that she's not in agreement with how the visiting hours are operationalised on the ward, but that she's not in a position to change the situation. Initially Olga referred to patient-centred visiting hours as being a privileged position (that could be taken advantage of by the patient and their visitors), but later suggests that it should be normal practice if 'we' (the organisation) profess to provide patient-centred care (05-O31/05-O32/05-O33-2). Later in the discussion Olga goes a step further: 'I believe there should be more of a hotel-type attitude to family and visiting as it is in the best interests of the patient' (05-O35-2). None of this was discussed with the team, even though she had maintained that she felt comfortable with, and part of, the team. It was not clear during this context of the discussion whether or not Olga's decision to discuss the issue was influenced by the power she perceived in the team. She did, however, admit to recognising differences in how colleagues engaged with and committed to patients (05-O43-1).

Olga went on to recount:

'I was working a late duty and there was a lady from Ghana who had a fractured ankle. And she sat the whole time with her rosary. This woman had been with us for a few days and I heard that she'd fled Ghana and was waiting for a residence permit ... and that her husband and children had been shot in front of her. This woman was so very sad and she sat continually with her rosary. And my feeling said: "this woman probably wants to go to the church." And I just took the woman and said: "guys, I'm going downstairs with this lady." And this was a very good choice for this lady and she really perked up. But later, when I got back, my colleagues said that it would have been better if I hadn't have done that in an evening duty because it's too busy for that (kind of activity). I understood that, but my feeling was strong that this was a priority for me. A wound dressing is a priority, but this is also a priority' (05-O17-1ff).

Our discussion is focused more on the setting of priorities and the tensions arising from the difference of opinion between Olga and her work mentor. After I switched the tape off and we were tidying the room, Olga went on to speak about taking the Ghanaian woman to the chapel. The following text is based on our discussion – or rather what Olga had to say – which I have permission to use:



As Olga pushed the patient around the corner into the corridor leading to the chapel, they could see an almost life-size white marble statue of the Virgin Mary. On seeing the statue, the patient began to clap and sing and cry – an outpouring of emotion. Olga slowed before wheeling the patient into the main body of the chapel. Once inside, the patient again showed an emotional outpouring of (what appeared to be) grief and religious ecstasy.

I asked Olga what she did and how she dealt with the situation, to which she replied that she did nothing and that she was ‘just with the patient’. This struck chords with me of work by Watson (1988) and Nåden & Eriksson (2000; 2002) on unconditionally ‘being with’. Olga had no notions of these writings, but was following her intuition and what felt right to her.

This led me to ask Olga how she experienced the situation – I could not resist asking whether she experienced this as a spiritual moment. She was aware, she said, that the moment contained a certain spirituality and ‘holiness’ for the patient and she felt quite overcome by the situation – she was amazed at the warm feeling it gave her. I went on to ask her about her motivations for entering nursing (bearing in mind that some students enter the profession from a religious perspective or perceive nursing as a calling), to which she replied that she had been brought up an atheist by her parents. However, the fact that she was now pregnant with her first child and overwhelmed by the concept of new life seemed to magnify the situation with the patient and she shared that she was rethinking what it (spirituality) all meant to her.

#### December 2005:

This is the first meeting with Olga since the birth of her son. At this stage she has been on the ward a little while after being away on maternity leave and, as can be expected, the dialogue focuses first on how she is and how she is coping with her new role.

For Olga to be back on a hospital ward meant fighting the demons of insecurity and she laughingly she said how much feedback she needed to boost her confidence (05-03.10). ‘I was an incompetent nurse, needing feedback.’ (05-03.41).

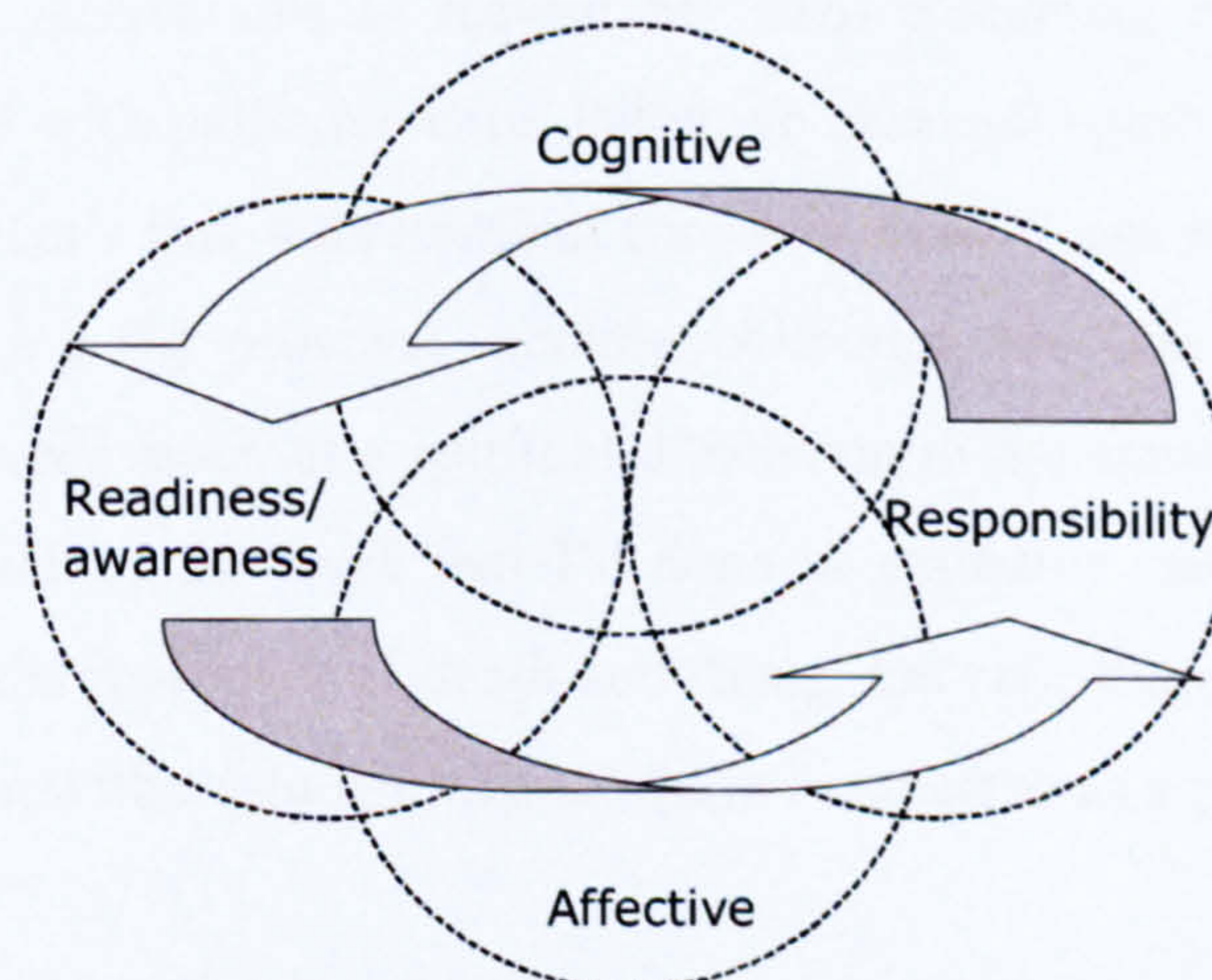


Interestingly, although feeling insecure at first about her functioning on the ward, Olga also found it was easy to pick up the ward routine (05-05.33) and hadn't found it necessary to undergo a full induction on the ward (05-05.48). Learning from the experience of a colleague who wasn't able to find a piece of equipment during an acute situation, Olga elected only to ensure orientation with regard to emergency equipment (05-06.12).

Although not articulated as such, I had a strong feeling that Olga's behaviour was based on wanting to integrate into the ward culture as quickly as possible and a desire to attain a level of anonymity within a new team.

The pressure of learning and working on a ward at the level of a final-year student seemed to be indicated in Olga's sharing that a four-year programme was very long (05-057.50) and that now, with the extra activities that motherhood brought, she was not always in the mood to study and that her evenings were filled differently (05-057.59). Olga found that learning on the ward was also less. Owing to the fact that, as a senior student, she was able to 'do' more and was therefore allocated more work, she now had to plan time consciously to look up information on the ward (05-058.24).

During the course of the discussion on learning it was apparent that Olga hadn't substantially altered the learning style she'd previously developed. She was aware of what she needed to do and was using the availability of colleagues in her environment to provide her with the emotional support she needed to take the responsibility she recognised. Conversely, she was aware of needing to make time to find the information she needed to function as a nurse on the ward (figure 5.6).



*Figure 5.6: Olga's learning process (December 2005) illustrated in terms of Castillo's (1974) model*



Olga was being confronted with a new category of patients on Ward A and realised she didn't know all there was to know about the specifics of such a specialised unit. She explained how she missed the specific information to inform her patients about the type of therapy they were having but, nevertheless, felt that she was able to provide the care they needed. Olga added that she missed insights with regard to the background and was looking forward to being attached to a ward as a registered nurse.

A move towards being a permanent staff member on a ward would provide her with 'more depth, rather than breadth' (05-059.45ff). Olga was ready to make the move from student to registered nurse status.

Listening to how Olga described her development made me reflect on work by Knowles (1980) in which he describes the dimensions of maturation. Olga had, in many aspects of this approach, taken on the characteristics of professional 'maturity' in this final stage of the programme.

Although the placement on Ward A was her third choice, Olga was happy with the placement (05-013.05). She had wanted a final placement on a ward that would allow her a confrontation with terminal illness and palliative care (05-03.57/05-012.26). Now, having been placed on this ward, Olga intended to use her final assignment to research how cancer patients cope and whether the nurses recognise the coping mechanisms, rather than labelling patients as being 'difficult' (05-01.03.11).

I found it symbolic that Olga had, in a way, initiated a discussion on spirituality by putting forward her motivations to request her final placement on a ward where she would be confronted with palliative care. Palliative care and spirituality are inextricably linked for me and Olga's link with terminal care was a cue to ask her about the situation she'd described during the previous meeting. Although the Ghanaian woman wasn't terminal, there was very much of a spiritual dimension to the situation. I am very aware that my own approach to the work that I'd done in palliative care had to do with my seeking answers to the mysteries of death and dying. On reflection, I seem to have been seeking identification with a (student) nurse whom I respected as a person and a nurse.

Olga seemed comfortable speaking about her previous experience: the most important insights the situation had provided for her were the importance spirituality has for healing (05-07.31), the realisation that 'small things' are



important to the patient (05-O11.03), that it was less important to fix your sights as a nurse on the 'standard/routine tasks of care' (05-O11.27), and the importance of looking further than only what patients 'say' (05-O11.55). There were, unfortunately, due to the short admission, no specific outcomes related to the patient's recuperation that could be directly related to Olga's intervention (05-O9.41). However, the situation resulted in a more personal contact and recognition between Olga and the patient (05-O9.44).

There had been virtually no further discussion on the ward regarding the incident (05-O6.59ff). The registered nurse who had been on duty at the time of the incident had remained unchanged in his opinion that it was inappropriate that Olga take a patient to the chapel during a late shift (05-O8.15). Olga, in her turn, didn't find it worth the effort to pursue the discussion and remained equally convinced that she'd made the correct decision and would do the same if she were confronted with the situation again (05-O8.57).

This situation that had been so symbolic, important and dramatic for me was summarised by Olga as being 'heavy' due to the discrepancy between the registered nurse's attitude and the patient's reaction (05-O9.58), but at the same time 'surprising' due to the 'warm feeling' Olga had had from the patient's response (05-O10.54).

I can relate to the fact that Olga hadn't pursued the discussion with her registered colleague – some things aren't worth the effort. Yet, on the other hand, I wanted Olga to get her 'pound of flesh' by confronting her colleague and 'winning' the discussion based on arguments defending the patient's needs rather than the ward's routines and rituals. Work by Espeland & Shanta (2001) and Leyshon (2002) resonates in my mind: they discuss the role of the educationalist with regard to enabling rather than empowering the student and, as a result, creating a situation of interdependency. What was this saying about me? Was I abusing my authority and, indirectly, using the student's trust for my own aims? Are my thoughts on the position and independence of the student uncovering a paternalism that I'm feeling uncomfortable to own?

Much of the discussion during this interview focused on the care for a terminal patient from another culture who appeared to be waiting for a close family member to arrive before dying (05-O14.51). In discussing the situation it became apparent to me how Olga was able to move through all the domains



in turn and be, therefore, comfortable in dealing with aspects of the situation as they arose (figure 5.7).

Olga appeared to be, emotionally, quite involved with the situation and I had the impression that she was almost willing the patient to live until the relative had arrived (05-O15.28). Her approach seemed to develop from her philosophical and spiritual reflections (Transpersonal domain) in which she saw the patient's 'good death' inextricably linked to the presence of the close family member and the extended family members who were almost continually present at the patient's bedside.

Her contact with the stakeholders (Extrapersonal domain) – family and patient – allowed her to interact with all the parties and create a situation in which she was able to provide optimal care for the patient and the family. Olga frequently referred to the family's reaction to the care and the depth of communication (05-O15.43/05-O20.34/05-O21.03/05-O21.10/05-O22.29/05-O23.55/05-O24.37/05-O28.41/05-O28.43). Central to this was the patient's comfort: whether that be promoted through 'artificial comfort' in the form of an inflated glove for the patient to hold in the absence of a family member (05-O16.07), the nursing presence to reduce the patient's angst (05-O17.11) or providing the opportunity for family members to sleep with the patient (05-O17.33).

Olga's emotional bonds with the patient and the family members were put to the test when the family requested that the opiate syringe driver be discontinued, apparently to delay the inevitable and allow the patient to be more conscious in order to bid her family farewell (05-O18.06/05-O18.45). Although not personally present at the time of the discussion, Olga was adamant that she wouldn't have agreed to this intervention as this could, potentially, have been detrimental to the patient's 'good death'. She didn't seem to think that a difference of opinion of this calibre would have put pressure on her relationship with the family, due to the fact that she'd invested in building a strong and balanced relationship with them.

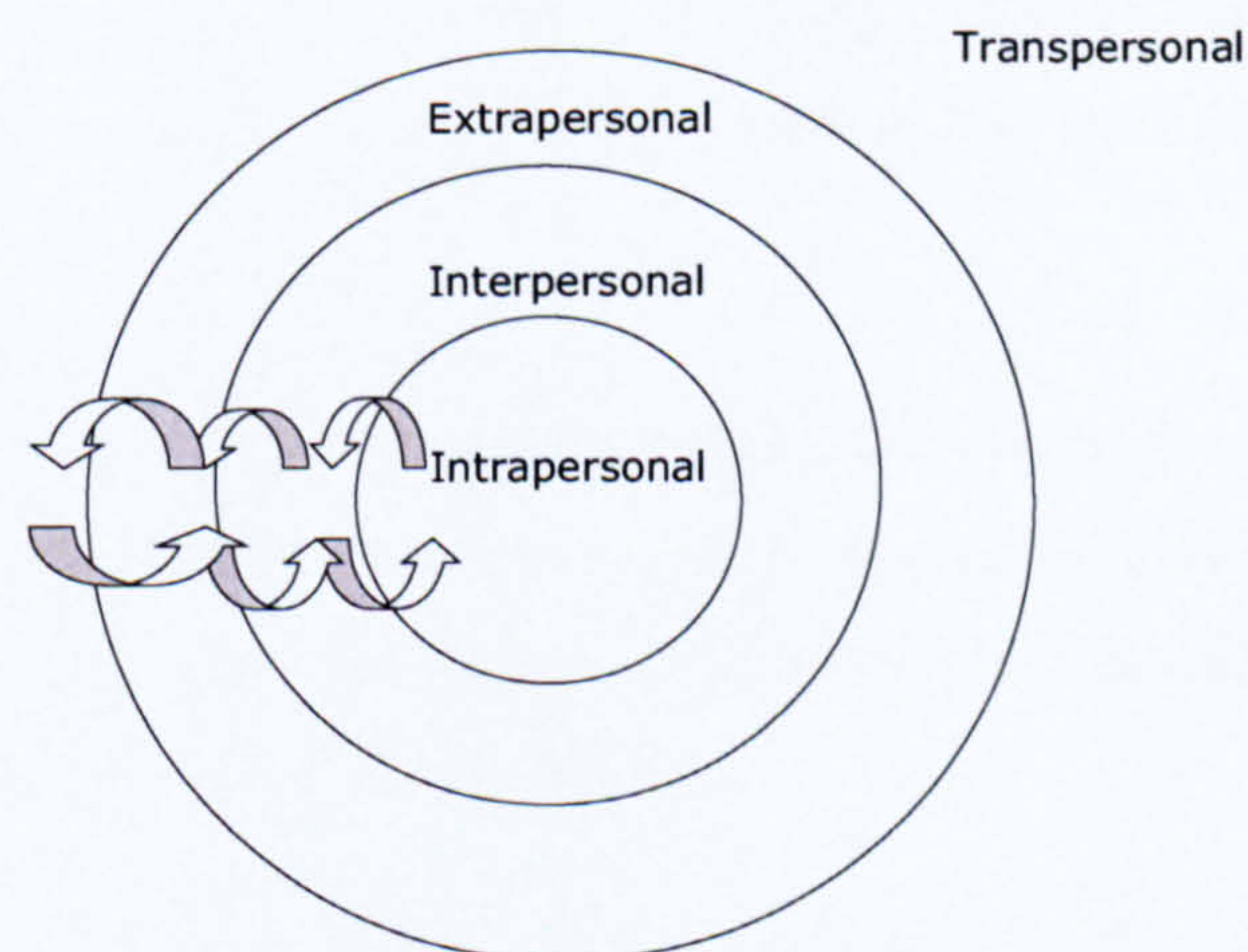
The multi-disciplinary team's approach was not to articulate clearly that the patient was in a terminal phase and would soon die even though that was apparent and both patient and family appeared to understand this (05-O22.29). Communication focused on the family and patient coping with the situation and all parties being brave and strong (05-O23.04) – this was due to the cultural implications of the impossibility that a doctor could predict death,



rather than respecting that Allah, alone, is all-powerful in taking or giving life (05-O23.30).

Although indirect communication appeared to be appropriate to the situation, Olga was aware of irritation within the (nursing) team that the doctor had given no clear message to the family that the patient would die within the foreseeable future (05-O27.00). The situation was compounded by the patient's rapid deterioration (05-O27.47) and Olga's perception that the family did not fully comprehend the situation and should be made aware that the patient could die soon after the awaited relative had arrived (if not before) (05-O23.55/05-O24.37ff/05-O26.40). These factors relating to communication with the patient resulted in Olga's addressing the issue with a more distant family member.

In terms of the DeMeulle & D'Emidio-Caston model (2003) (figure 5.7) and based on the complexity of expectations between the patient, family, doctor and nursing staff (05-O25.54), Olga seemed automatically to incorporate the interpersonal domain regarding communication and group dynamics by deciding to broach the issue of the patient's imminent demise.



*Figure 5.7: Olga's learning process (December 2005) illustrated in terms of the DeMeulle and D'Emidio-Caston (2003) model*

Potentially there could have been a situation of conflict at this stage: the family not having been clearly told before of the grave situation, while Olga believed that they were perhaps not being realistic in their expectations (05-O28.41) as they had spoken about the patient returning home (05-O28.43). Olga felt that the family's approach to the situation could have influenced their motivation to reduce the opiate dosage – perhaps not being ready to let go of the patient (05-O29.46). At the same time, Olga was questioning the



family's religious beliefs – only Allah holding the power of life, while simultaneously being prepared to use medical science to retain life (05-O30.10).

From an intrapersonal perspective, at night when she was awake to care for her son, Olga was initially emotional about the situations on the ward (05-O36.50ff). She would find it 'really awful' that people could get 'so sick' (05-O37.40), had visions of how the patient reacted to their illness (05-O42.12) and reflected on the quality of care she'd provided (05-O37.49). She would worry about small things she'd forgotten, but would wait until almost dawn to 'phone the ward' (039.27).

This 'confession' caused mutual hilarity as I shared that, when working on a ward, I would phone the ward in the middle of the night if I remembered something, and otherwise I wouldn't be able to sleep.

For Olga, the nights, when awake, were 'the worst'. In her thoughts, which were dependent on the degree to which a patient 'touches you' (05-O39.55), she appeared to be reflecting on the concept of human morbidity and mortality (05-O40.25) – it is 'sad', she concluded (05-O41.02). However, she was clear that once a patient died, the situation was closed for her (05-O41.25).

At this stage Olga seemed to move back through the domains of the DeMeulle & D'Emidio-Caston model (2003). Having reached the emotional and personal reflections on values, Olga communicated with private (05-O41.08) and professional (05-O41.13) networks in order to make sense of the situation.

We discuss the importance of psychosocial care and the fact that it's often not included in the patient's care plan (05-O48.13ff), but how difficult it is to articulate what the nurse has done with the patient. Owing to the time constraints, psychosocial care seems to have a lesser priority (05-O48.13).

Olga seems to identify a 'conflict' between the team's expectations and her own with regard to the quality of care she wants to provide: 'psychosocial care takes more time' (05-O49.15) and 'it can be heavy' (05-O49.55). Trying to find a balance between her values and those of the team, Olga indicates that she sets boundaries by cutting contacts short (05-O50.00): 'due to the number of patients, you protect yourself.'



Normally Olga doesn't reflect on this – only after discussions with me (05-O50.22). I find this quite an unnerving perspective, as I am tending to make her aware of the situation she works in, without actually helping her to address the relationship with the ward culture. I feel a sense of relief when Olga goes on to say that she finds it valuable and identifies that she needs time to recognise problems and take any form of action (05-O50.53). It becomes apparent that Olga recognises the dilemma and conflict around psychosocial care and the ward culture (05-O54.29).

The major cities in The Netherlands being multi-cultural, I am curious to know how comparable Olga's palliative care is for a patient from another culture to providing the care for a patient from the Dutch culture.

Olga is of the opinion that in palliative care, although the patient is central, the nursing care is often directed at providing support for the family (05-O33.06): 'it (the care) is not really related to ethnicity, but more to the personal contact between nurse and clients' (05-O32.22). Olga suggests that the relationship differs per family/patient (05-O33.00), but depends on the nurse and client's 'openness to share' (05-O33.48). The relationship is largely based on basic elements of respect, such as introducing yourself to the family members (05-O34.17/05-O36.05) – something we 'learn from our parents' (05-O34.24).

Olga's knowledge and skills in relation to her colleagues appears to surface again. Although she has continued to develop in her skills, she seems to have reached a plateau in learning to provide physical care and is able to function independently (05-O41.57/05-O42.00). Her ability to provide psychosocial care is still in development and Olga indicates that she perhaps still needs to develop more 'feeling and empathy' (05-O42.00ff). She seems uncertain as she tells of how she 'sets priority to talk to the patients, rather than doing routine observations' (05-O43.17), but tries to find a balance. Her uncertainty seems to stem from the fact that she could probably 'be more productive', if she 'paid less attention' to the psychosocial aspects – an exception being if the patient is poorly (05-O44.43/05-O44.56). 'It's difficult to find a balance (between psychosocial care and physical routines)' (05-O44.18), 'so that means I'm always very busy with things' (05-O44.30). The dilemma for Olga is that 'the ward' expects all to be done by 3 pm (05-O45.15) – a perceived pressure exists to have tasks completed by a set time: 'others may think that I haven't done anything', but Olga indicates that she is 'satisfied with her own



choices' (05-O46.47). Olga appears to find it difficult to articulate what she has done with the patients and so appears not to see psychosocial care as work (05-O47.11). During the drive home after her duty, Olga seems able to objectify what she's done and is then able to verbalise it (05-O47.45), but not when confronted by what she perceives to be peer pressure on the ward. She finds it difficult to hand over care still needing to be given (05-O52.00).

In her final reflections on her journey through the programme in June 2006 Olga seemed to think that experience would resolve many issues and provide the stability for the river of her nursing career to flow serenely forward. At this stage, however, she seems still caught up in the red/ yellow/orange turbulence of her final year in trying to find a balance between attachment and commitment to her patients and their families. It seems almost an expression of disillusion when she notes that even experienced nurses have to deal with irritations from patients and family (05-O54.10).

Olga's articulation of the reality of professional life seems to cause her to become more reflective on her professional role in relation to the patients she cares for: 'I am able to embrace the patient in my heart, but also to close off afterwards' (05-O55.10) '... I don't believe in distance if you don't have a problem with it' (05-O55.29) '... it's not a problem to think about the patient at night' (05-O55.48) '... you click with some patients and they touch you – it's not strange ... they make a major impression on your life' (05-O56.55). But it's also not a problem if patients don't 'touch you'; as long as 'you're professional in your attitude it shouldn't affect your care' (05-O57.31).

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'Olga,' I ask, 'is there anything else you'd like to share before we end the interview?'

'Yes, after the birth of my child, I was first surrounded by life and now I'm surrounded by illness' (05-O1.05.06) '... I have more empathy due to motherhood ... I identify with other mothers (patients) when they're going to die and leave their children behind ... it is so sad and beautiful at the same time' (05-O1.07.40).



## *Linda's widening and winding path*

### *Introduction*

Linda is a 40-year-old female nurse, it was a winding path to her current position as a nurse in the Netherlands. She has a degree in nursing from the University of the West Indies, St. Vincent.

She is a very experienced nurse and has worked in various settings, including a hospital, a community health center, and a private nursing home. She has a strong background in patient care and has been involved in many projects and initiatives throughout her career. She is a very dedicated and hardworking professional who is always looking for ways to improve her skills and the quality of care she provides. She is also a very team player and enjoys working with others to achieve common goals. She is a very approachable and friendly person who is always willing to help others. She is a very motivated and goal-oriented individual who is always striving for excellence in everything she does. She is a very professional and ethical nurse who is always acting in the best interests of her patients. She is a very caring and compassionate individual who is always willing to go the extra mile for her patients. She is a very dedicated and hardworking professional who is always looking for ways to improve her skills and the quality of care she provides. She is also a very team player and enjoys working with others to achieve common goals. She is a very approachable and friendly person who is always willing to help others. She is a very motivated and goal-oriented individual who is always striving for excellence in everything she does. She is a very professional and ethical nurse who is always acting in the best interests of her patients. She is a very caring and compassionate individual who is always willing to go the extra mile for her patients.

## **SECTION SIX**

### **Linda's widening and winding path**



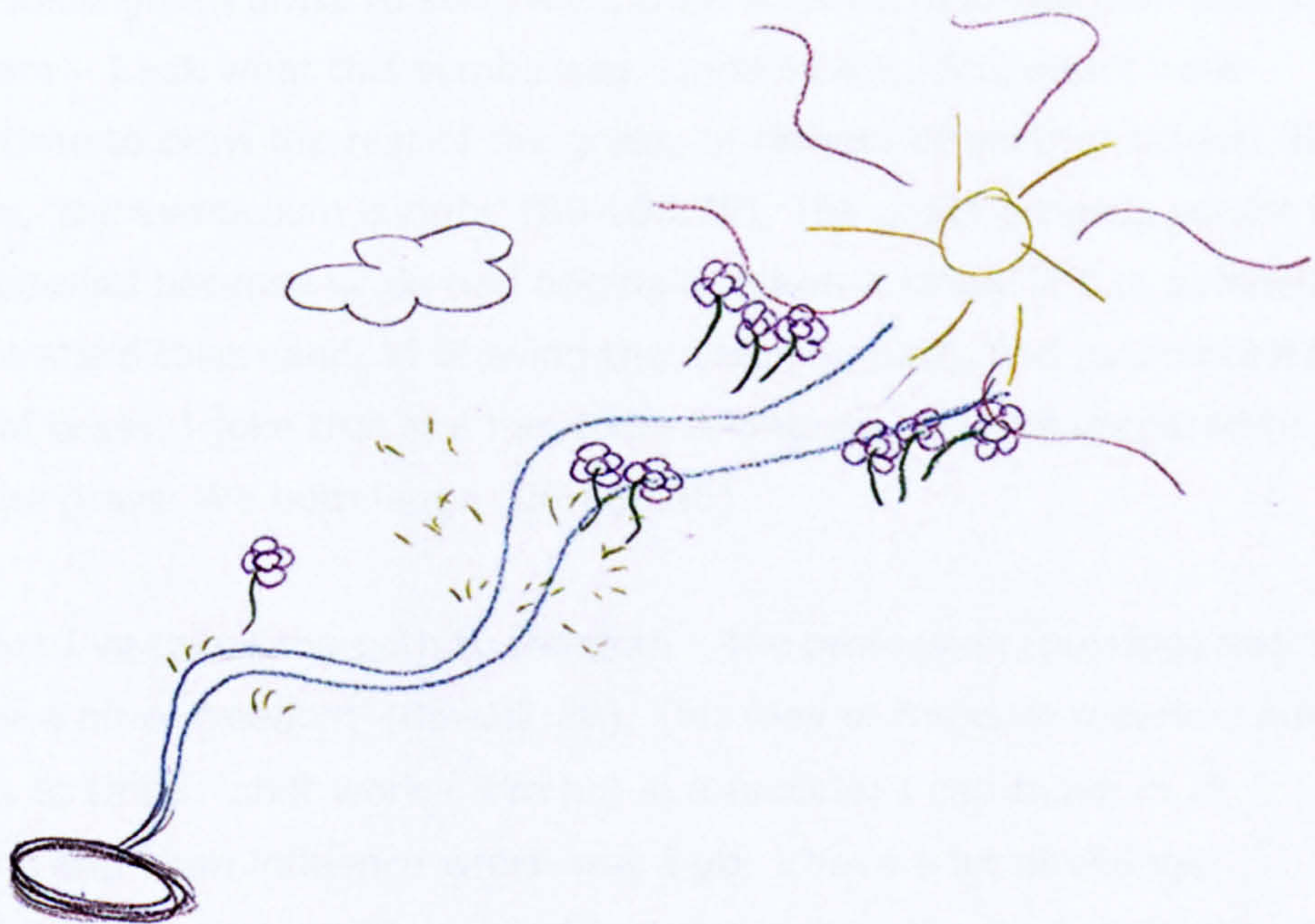


### Linda's widening and winding path

June 2006:

'Black is the hole I came out of. It was a turning point for me. Pure insecurity ... I needed to find my way' (06-L00.31).

'Blue is "my path". It was narrow and got broader as I felt safer. With my personal development, slowly there were more flowers – that had a lot to do with the black hole' (06-L00.50). Linda explains how she'd started using a black pencil to draw her path, but it was too 'sombre', but that there was no real reason for her choice of colour: 'There's not really a symbolism, but it had to have a colour' (06-L03.42). Initially Linda had drawn a single line for the path, but then thought that it needed to get broader as she progressed through the programme (06-L09.03). The path drawn from bottom left to top right just 'had to be' like that. At an unconscious level – according to Linda – it is the hill out of the valley (black hole): '... I followed the route to freedom' (06-L05.04). 'The path is winding, you don't know where it will lead, but the direction is right ... but it's not straight' (06-L11.13).



*Linda's widening and winding path*



'Halfway there was a cloud on the path ... personally ... my relationship broke up ...' At the same time Linda had a mental health placement which she didn't like: 'It was a dark period in my training' (06-L01.12). 'But I've come through and I'm on my way to the sun' (06-L01.44). Linda tells how many people around her have said that she's 'completely happy and free' – Linda describes feeling free: 'I'm going to travel for the first time and it's to work (abroad)' (06-L01.57).

'The red lines radiating from the sun are my possibilities. I've done the training and can go in any direction. I don't have to stay in a hospital, but I can go in any direction' (06-L02.03). The first of the red lines Linda is following is eight weeks of voluntary work in Africa after her graduation (06-L32.29).

Although, as Linda explains, there's no real reason behind the purple colour for the flowers, the numbers are significant. As she perceived herself to be climbing out of the valley (black hole) and up the slope towards the sun, more flowers appeared: 'Certainly in the first year I found it heavy ... psychologically heavy' (06-L04.30).

There's some green grass to start with, then it grows over the path and finally disappears – I ask what this symbolises. Linda laughs. She didn't have enough time to draw the rest of the grass, or flowers of another colour: 'But,' she adds, 'the symbolism is right' (06-L08.35). The grass growing across the path happened because Linda had originally drawn a single line to symbolise the route she'd taken and, in drawing the widening path, had incorporated the clumps of grass. I joke that she has come a long way if she's prepared to walk across the grass. We both laugh (06-L09.16).

'I feel that I've taken the path to freedom – the profession (nursing) has given me a bit of freedom' (06-L02.20). This idea of freedom means a number of things to Linda: 'shift work – I'm not in a routine; I can move in all directions and I can influence which way I go; I have a lot of change (diversity) in my work and I can find (create) it myself ... I have the freedom to show initiative and do things on the ward ... there's no pressure to adapt' (06-L02.37).

Linda explains more about her feeling of freedom. Prior to commencing the nursing programme she was home on sick leave from her previous job for



seven months: 'I chose nursing to be able to mean something to people, and not so much for the freedom' (06-L05.50).

During her period of being home from work Linda tried numerous times to reintegrate into work, but each time she had a 'nudge' back home: 'I had to do something different' (06-L15.20). 'I had to do something I liked ... not for the money or career ... that wouldn't make me happy. And then a kind of snap (clicks her fingers) ... that's it, I need to care ... (then in a quiet voice) that was it actually' (06-L15.58). 'When I'm 80,' Linda laughs, 'I need to be able to look back on my life and have the idea that I've meant something for people in a human way' (06-L16.20).

On the first day of workshops in 2003 Linda had chosen a photograph of a contrabass (double base) player to symbolise her nursing vision of being open and free. Her own freedom was not, initially, her motivation to choose nursing but is an extra dimension: 'I'm freed from my suit of armour<sup>3</sup> – I had to burst out of the armour I was in and follow my feelings (intuition) more' (06-L06.25). 'I was also stuck in a relationship ... the (nursing) programme wrested me from life as it was ... I fit well in my skin now<sup>4</sup> ... the path is getting wider ... I have never felt so good' (06-L07.05). 'I'm really standing in the sunshine now. Just for a while it blocks out ugly things.' (06-L35.00) ... and: 'I'm in love again ... this time for real.' (06-L41.11).

Linda tells how she was afraid at the start of the programme, but through positive experiences with patients, colleagues and cohort members she learned to take more risks and be open to other people who crossed her path (06-L22.25): 'It's been a good programme and I'm left with a couple of very good friends' (06-L42.22).

Hearing Linda speak at the end of the programme, shortly before her graduation, makes me curious as to her journey and whether I am able to identify the widening and winding path as it developed. I return to the beginning ...

December 2003:

We are in a focus group discussion and one student is telling how she felt she was given much responsibility as a starting-out student. Linda listens attentively but then disagrees. She thought she would be given her 'own'

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<sup>3</sup> In Dutch 'bevrijd van mijn harnas' literally means to be freed from a suit of armour – in other words, freed from a claustrophobic and/or restricting situation.

<sup>4</sup> 'Goed in mijn vel zitten' literally means to fit one's skin well – to feel comfortable and happy with oneself.



patients after a six-week introductory period on the ward and was 'very nervous' at the thought ... and then asked what the ward's expectations were: 'They reassured me that I wouldn't have to do everything at once and know everything there was to know' (03-L40). She goes on to say how exciting she found having her 'own patient' and to share the responsibility: 'And at first nothing will move you from the room (giggles) you're busy with all ... everything ... and, yes, there comes a moment when you leave that idea ... but you have to get used to it' (03-L43).

Linda goes on to say that one of things that made most of an impression on her was the way people cope with their illness. Seeing one patient who was pregnant undergo a procedure without anaesthetic, Linda says: 'And I thought she was so brave and it was so painful that I almost cried myself (giggles) I really had a problem with it.' (03-L50) '... it can also be an example to me; that if I have the flu or don't feel well that I shouldn't whinge or gripe ... some people are so strong ...' (03-L52).

We are talking about patients having something to do while in hospital. Linda would, in time, like to research how patients feel about the passivity inherent in a hospital admission (03-L91-96). Boredom, she feels, must be a dreadful thing about a hospital stay.

Three years later Linda remained true to this idea and wrote her final assignment on patients socialising into the hospital system and the role of staff in preventing this happening.

In response to the other focus group members complaining that they're not able to do any 'extras' for their patients because colleagues keep asking them for help, Linda turns the discussion around: 'Have you had it the other way around? That you've not finished with your work and that someone else ... Well, I have experienced that often enough that at 16.45 you still had to finish ... Well at that moment I find it very nice that someone helps me finish my work ... who does your obs (observations), or something else ... It does work from two sides ... And at that moment I appreciated it. So therefore I'd do it the other way around too ... certainly' (03-L161/03-L166/03-L170/03-L175/03-L179/03-L184).

Linda adds that communication during the day's evaluation is important – during the evaluation it's good to try to find out why it was necessary to help



each other – perhaps the work needs to be allocated differently for the next shift (03-L195/03-L201).

Communication seems to be an important focus for Linda. While others in the focus group are saying they're not able to take their patients for walks in the main hospital thoroughfare or outside in the adjacent park, Linda tells how she takes her patients for a walk in the corridor, where she is more or less visible, but still accessible to the ward to answer questions and still be providing her patient with a chance to mobilise: 'So if you go to the park and you've got six patients, you leave five behind for your colleagues – that's how I see it' (03-L275-282).

'Only' midway through the programme Linda tells of her difference of opinion with a doctor regarding the (premature) discharge of a patient. She did not agree with the patient's discharge and tells 'triumphantly' that the patient was readmitted at 2 am the next morning. This 'one-upmanship' hasn't, however, given Linda the confidence to challenge the medical staff – this would be 'too cheeky' (03-L437). Linda does, however, seem more comfortable than her two colleagues when it comes to questioning and challenging colleagues. She seems quite amused when registered colleagues have a 'yes, that's what we always do here' approach (03-L451). And realising that her registered colleagues don't always know the answers to her questions provides her with the courage to ask about the whys and wherefores of patient care (03-L454).

Linda is very conscious of feeling responsible and wants to go home with a 'clean' feeling, not having made any mistakes or having left 'things undone'. She gives an example of a colleague who'd given her a phial, saying it was an Insulin type. On the way to the patient, having drawn up the dosage, Linda realised she'd not checked the label and thought: 'I can just give it, or go back and check' – she went back to check. Linda giggles: 'I want to go home clean ... I think I'm not going to make a fuss, but then my conscience starts playing on me during the day ... and I think: no, I'm going to do it anyway' (03-L323-335). 'I don't want the patient to be short-changed because I'm too lazy ... I sometimes think: is this really necessary? But I do it eventually anyway' (03-L339-342). 'If I don't (double check), then I mull (over it) at home' (03-L352).

The combination of feeling responsible and 'daring' to challenge colleagues allowed Linda to question the accuracy of ward apparatus, resulting in clinical



lessons being organised for the team. This gives her a good feeling: 'And that I really like' (03-L455-461).

Throughout the discussion on communication and challenge Linda appears to listen carefully before responding and seems comfortable in challenging her peers in the focus group and combining her input with good-natured humour.

There seems to be a good deal of reference to 'daring' to challenge, to extend boundaries, to suggest patient care and generally to be visible as a student. Without actually naming it Linda seems to pick up the gauntlet and take a stand. She talks of her way of learning on the ward ...

In the first instance she tended to follow her mentors around and watch what they were doing: 'I didn't dare (have the confidence) to do very much' (03-L565) '... and then I started getting panicky.' Linda realised that by not actually 'doing' anything, she would never develop the skills (03-L568). 'I now get told, as a sort of reprimand, that I'm too independent' – 'but that is a way for me to learn' (03-L573). Linda tells that she's developed a method of showing what she's capable of and that she knows she'll 'never do any irresponsible things'. 'So they trust me. So for the rest, I can just do my own thing in a way' (03-L575). This has become Linda's way of learning from situations: 'If I work together with someone, it's as though my hands slowly disappear behind my back and I just don't do anything. And if I do it myself, my hands come out of my sleeves and I can really work well' (03-L577-580).

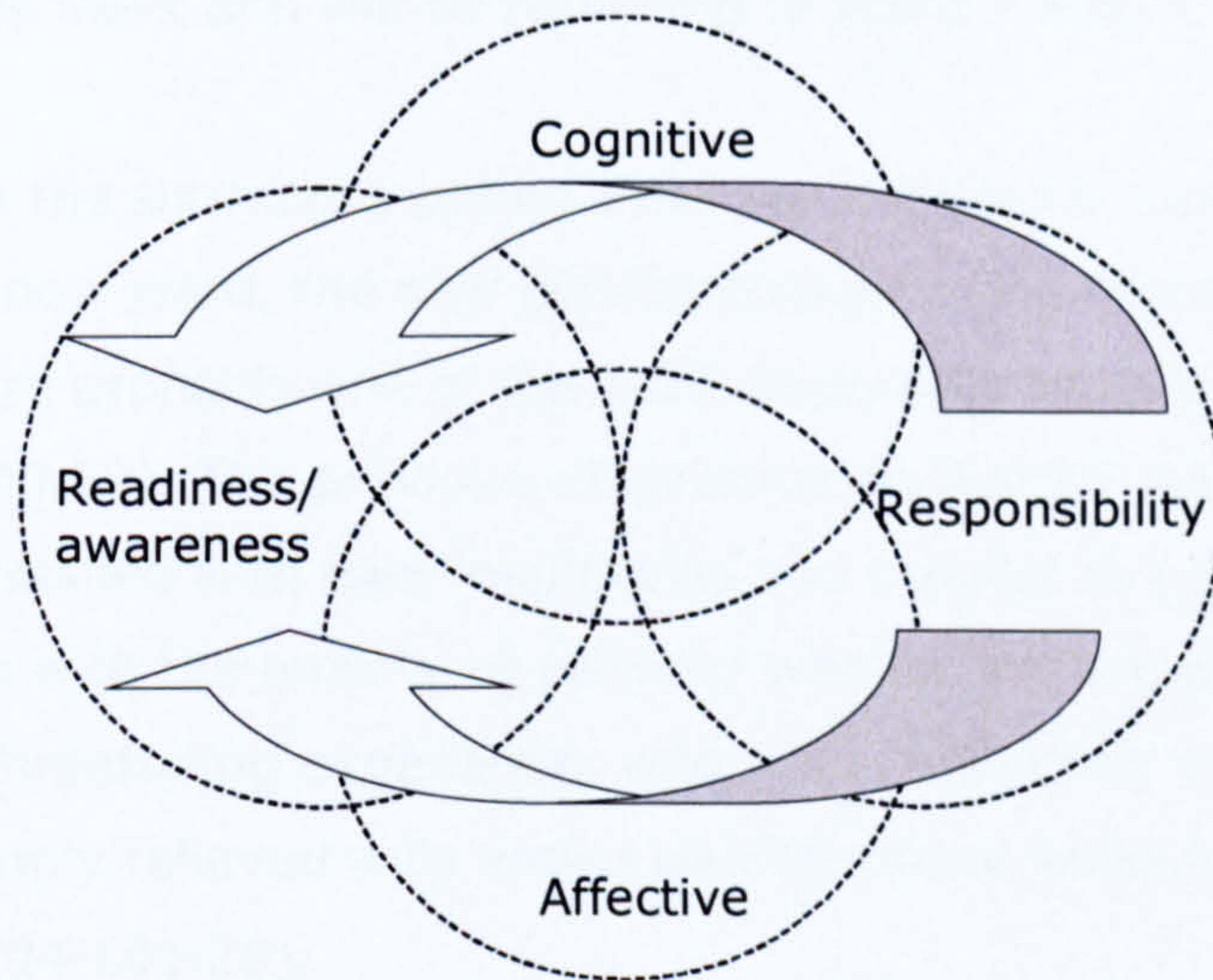
I'm curious that Linda seems to take less initiative when she's linked to a mentor. She responds with a snigger: 'I think because I'm afraid to do it ... I find it terrible if someone watches my fingers. I really find it dreadful. I get quite jittery from it. (laughs)' (03-L586-588). She goes on to tell how she's able to talk to the patient when she's alone with them, she puts them at ease and then feels at ease herself, but needs time to develop the contact. She admits to making mistakes, but also confesses to relying on her feelings of responsibility not to put the patient at any risk. The presence of a registered colleague or mentor would make her feel nervous and she'd be more focused on the procedure than on the patient AND the procedure: 'I sit there with a complete split personality. (laughs) Yes, it distracts me terribly.' (03-L603).

Although uncomfortable with being observed while she works, Linda is clear that if she needs to learn a new procedure, she makes appointments with her mentors for a



demonstration and another appointment to actually execute the procedure together. She explains how she's afraid to be left completely to her own devices and that optimal learning is closely related to having her mentor as a back-up to answer questions and advise (03-L611-619).

In terms of Castillo (1974) Linda seems led by her feelings of responsibility to develop the attitude and knowledge and skills necessary to be ready to face the situations she encounters (figure 6.1).



*Figure 6.1: Linda's learning process (December 2003) illustrated in terms of Castillo's (1974) model*

Two years into the programme and Linda is seeing a change in the way she deals with situations. Entering the nursing programme has been an important move: 'If I look back to 18 months ago, then what had I been doing all those years?' (03-L655). 'I notice that if I um ... if I've worked, I'm different at home ... in the hospital I'm far more self-confident than in daily life ... I stand ... yes, I stand proud for the things that I do ... and I at home I have that far less. I notice a marked difference when I haven't worked, then I feel less happy' (03-L685-692).

A little later Linda explains more about how important her relationship is with the patient and the degree to which she's focused in the interaction – she needs to be able to 'suss' out the other person and 'what they can appreciate':

'But then you're busy on a 1-to-1 with the patient, so I don't really take notice of what's happening on the ward. I feel that it's then my thing with the patient' (03-L716-719).



Her person-centred approach is clear, is directly linked to her norms and values and is, to my way of thinking, based on intuition: 'I think it's a question of feeling. I'm not someone who makes jokes, say, about someone. I make jokes with someone so that they are able to laugh, say, but not at someone else's expense' (03-L727-733).

June 2004:

Linda is on a 10-week mental health placement which she's not enjoying (04-L50.53) when we meet and will be returning to Ward F within a few weeks.

Looking back on the six-month period since we last spoke, Linda tells me that adapting to the new ward, the new patient category, the illnesses and new colleagues – were probably one of the most important aspects she's had to deal with (04-L00.59). The previous experience on Ward E was surgical and patients were satisfied with pain medication and comfortable dressings; she now has to deal with the anxiety of patients who've had a frightening and potentially life-threatening experience, who react differently to pain – pain that can't be simply relieved with analgesia: 'It's more serious and you have to deal with it' (04-L01.28).

Feeling responsible is very important: 'Ward F is scary – you're on the border of life and death ... if I make a wrong assessment, it could mean death ... I find it scary and (spoken softly) can't really deal with it ... do I press the resuscitation alarm or not? ... sometimes I feel panicky' (04-L02.12/04-L02.49).

Linda is aware that she'll need to develop her skills on the new ward to the level that she's able to take the responsibility for seven patients but has a plan of action in mind: First she has to understand more about the illnesses presenting on the ward through reading and discussion. Then she needs to identify the signs and symptoms that accompany the illnesses – this can be achieved through talking to the patients. Finally, Linda feels she needs to differentiate between the complexity and severity of the illness (04-L29.07/04-L30.44). All these points were discussed in a progress meeting prior to Linda's being seconded for her mental health placement and the mentorship style on the ward was adapted to suit her situation – rather than being allocated a full four- or six-patient bay, the patients on two bays were allocated to Linda and her mentor; each had half the patients in each bay. In this way both student and mentor are regularly in each bay and this prevents



Linda from working too much in isolation or too independently (04-L31.55): 'I don't mind working on my own and I have a good overview because the patients are largely independent and only need to be observed but if something happens, you need to act' (04-L33.51). I'm curious as to how Linda determines complexity: 'I'm aware of the risks and have confidence in the quality of my work. And I have an overview of what can go wrong – I work responsibly' (04-L34.58). I feel quite awed by the way Linda – halfway through the nursing programme – explains the subtleties of her observation. She observes and identifies the patient's signs and symptoms, and combines her observations with communication: 'You just see it (that a patient's not well). The way that someone reacts and you communicate with the patient ... that's an important source of information – the patient' (04-L34.58/04-L36.12).

I enquire about the 'just see' aspect of Linda's observation – it sounds almost as though it's an intuitive knowledge and I want to know what knowledge she bases her decisions on. Although it's difficult without a specific example, Linda tries to make me understand that she observes the way the patient lies in bed, their facial expressions and any noises they may make, their breathing, colour and sweating. She relates her observations to the information she's had from the report and together this provides her with a framework in which to place the patient and their illness. Her frame of reference is a patient who, although ill, is not in a life-threatening state. Anything out of the ordinary is cause for alarm (04-L39.17/04-L40.19).

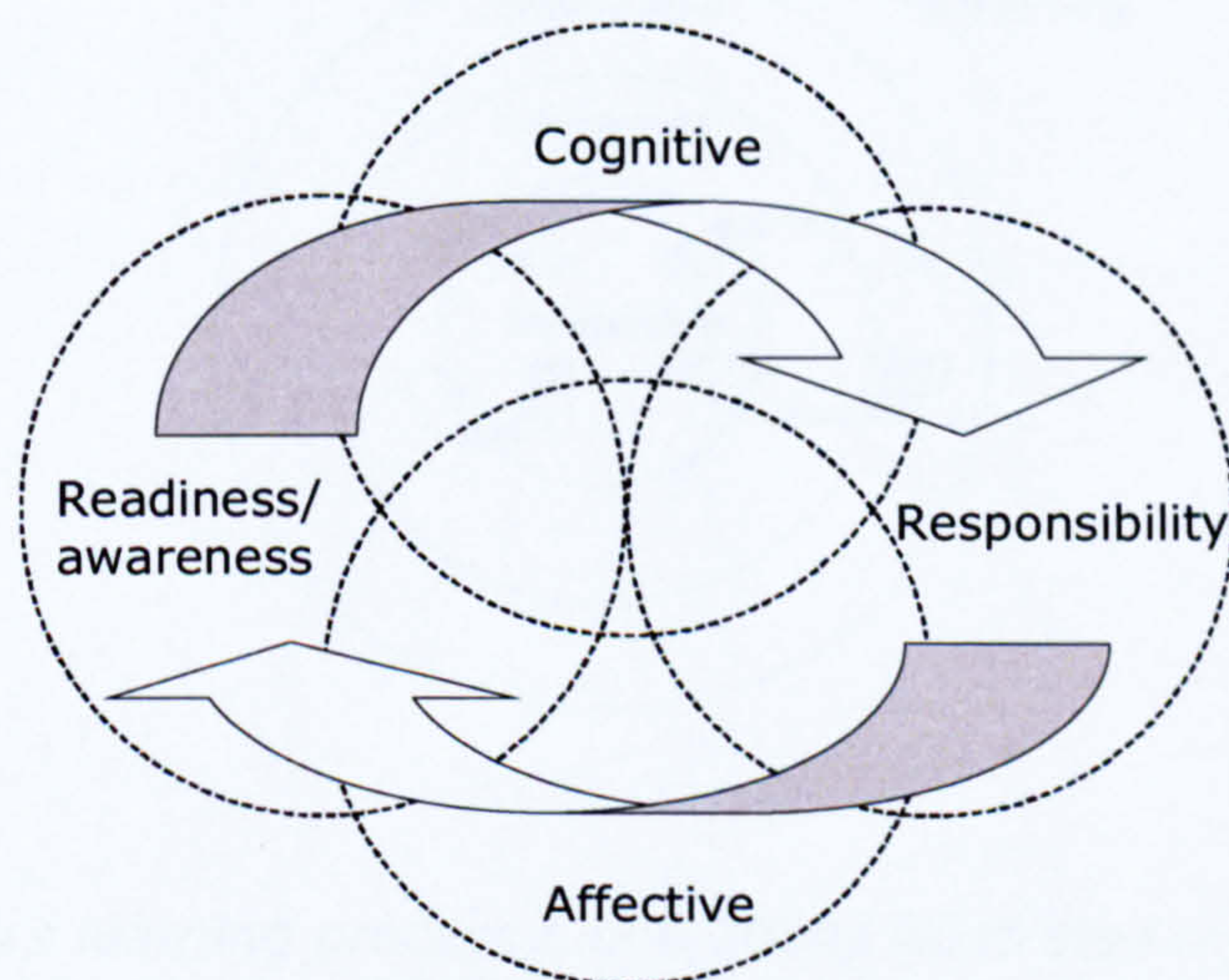
I've been wanting insight into Linda's decision-making as she had already told me about a patient she'd discovered hanging halfway over the cot sides of his bed – clearly an 'out of the ordinary' situation. She had chosen to leave the patient and call her mentor who was in the passage outside the room. I am curious as to Linda's rationale to decide to leave the patient to get help, rather than stay with the patient and press the alarm bell (04-L42.16).

'I was afraid that I'd made the wrong assessment – I was really scared. I've had the Basic Life Support training, but I think it'll be terrible to have to actually do it ... really very scary' (04-L44.00). 'It wasn't a resuscitation, but the patient could have arrested – it wasn't good that I walked away. I find it really scary' (04-L44.56/04-L45.20). Linda was 'so afraid' that she'd have sounded the alarm bell inappropriately, but felt she wouldn't have lost face on the ward even if it was a false alarm: 'I was afraid that I'd done wrong – a



shame about all the extra work and it creates panic and disturbance for the other patients in the bay' (04-L46.07/04-L47.21).

I find Linda's explanation intriguing. On the one hand, she experiences a heavy responsibility with regard to life and death decisions and the onus on her to make accurate and appropriate decisions, while, on the other hand, she chooses not to sound the alarm bell when a patient has become acutely unwell. In terms of Castillo (1974) Linda now seems to identify her responsibility from an affective perspective and then interprets her readiness to act by accumulating the knowledge necessary prior to action (figure 6.2). Although she hasn't admitted to it, it would appear that she is afraid of jeopardising the way her colleagues and mentors view her – she holds firmly onto the idea of not doing something unless she's 100% certain that it's correct (04-L48.29).



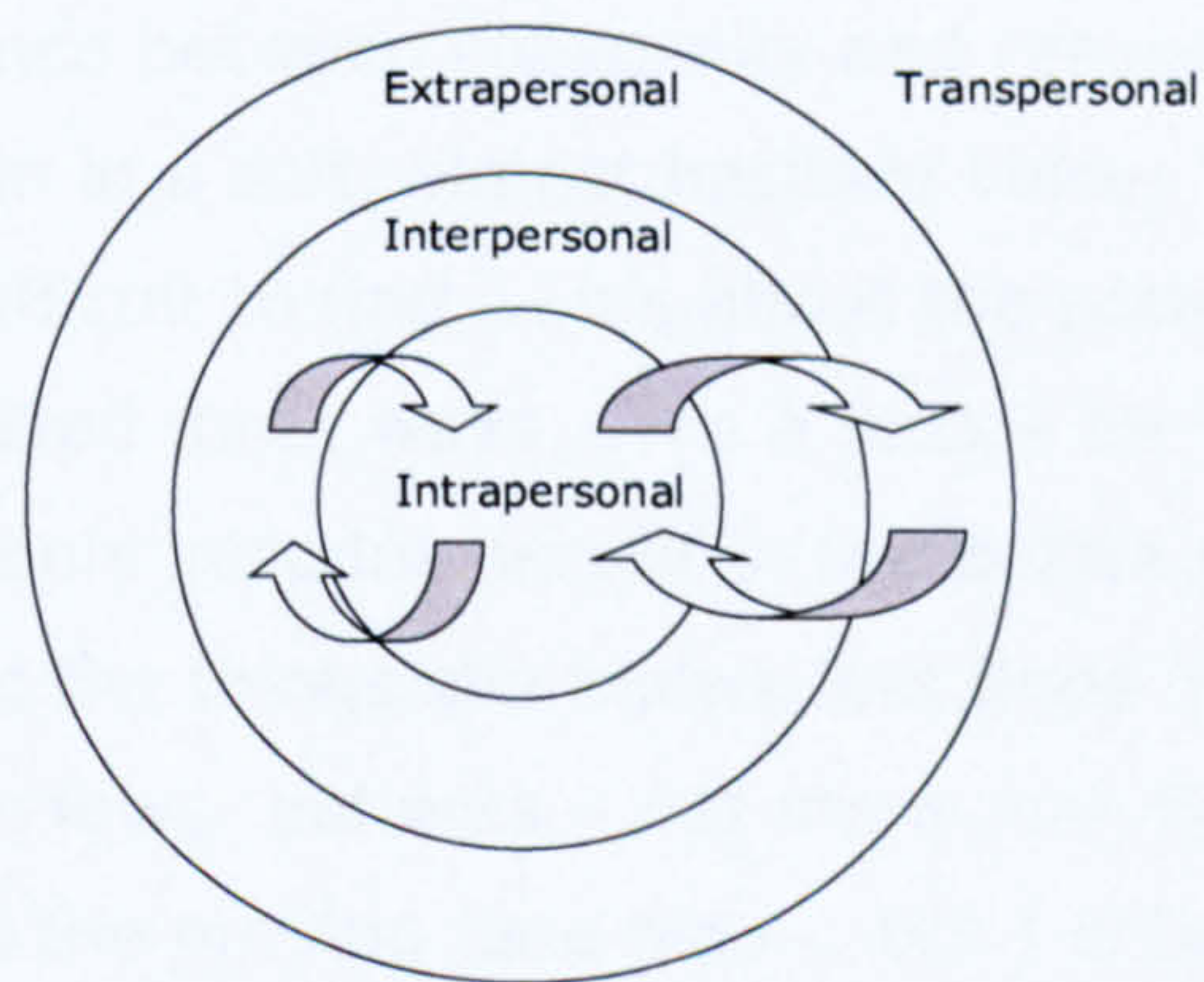
*Figure 6.2: Linda's learning process (June 2004) illustrated in terms of Castillo's (1974) model*

The first duty on Ward F didn't go well for Linda. There was an acute situation with a patient and she needed to fetch apparatus and telephone the doctor – this is when she discovered that she didn't know where to find anything on the ward as she hadn't had an induction or orientation. During our discussion Linda seems, initially, to take full responsibility for the situation: 'Stupid that I didn't know it.' (04-L04.14). Then she seems to place the situation into a more realistic perspective: 'Now that we're talking about it ... it's not good that I didn't know where anything was ... a short induction would have been good' (04-L04.47/04-L05.54). Linda is spontaneous in what she sees as being her moment of learning: 'It's a shared responsibility (mentor and student) ... but I could have asked for it myself' (04-L05.01/04-L06.09). 'As a professional nurse you should have these things in your head (knowing where



things are in an acute situation) if you are going to take responsibility. It fits the profession (professional role)' (04-L06.18).

Linda seems to me to take her feeling of responsibility quite far – even to the point of taking responsibility for an induction that should be a routine procedure on a new ward. Her personal beliefs, values and thoughts (Intrapersonal domain) appear to be interfacing, on the one hand, with aspects of group leadership and interpersonal communication (Interpersonal domain) and, on the other hand, areas of organisational dynamics, professional standards, stakeholders and ward politics (figure 6.3). In terms of DeMeulle & D'Emidio-Caston's (2003) model, interaction between the domains, however, appears to be in isolation, rather than complementary.



*Figure 6.3: Linda's learning process (June 2004) illustrated in terms of the DeMeulle & D'Emidio-Caston (2003) model*

Linda explains how she needs to get over a threshold and take the step towards carrying responsibility for her patients. During, and after, her first experience on the ward Linda was doubtful whether she'd be able to function as a nurse: 'There were so many things I had to know – illnesses and medication ... but it's important to discuss the patient in detail with your mentor before actually going to the patient' (04-L09.19). Linda tells how, on Ward E, she started by being allocated one patient when she was supernumerary. She gradually built up her workload until she was included in the ward norm and had the same number of allocated patients as her colleagues – a maximum of 7 (04-L09.53). On a surgical ward it is, apparently, easier for a student to care for a full complement of patients due to the routine use of protocols and clinical pathways. This feeling of security is, however, short-lived if a stable patient develops untoward complications (04-L14.27/04-L15.23). I am curious about how Linda views her responsibility



if the security she offers her patient is so precarious – this slant to the discussion uncovers a new dilemma: 'If it's busy or you're short of staff ... the people (patients) need to be cared for ... if I don't do it (take the full complement of patients), my colleagues will NEVER manage. It has to do with collegiality and that is sometimes skew' (04-L16.27). Linda needs to find a balance between collegiality and responsibility and I try to push her further into articulating how she sees this (im)balance of accepting to care for seven patients while not having a full overview of the potential risks and complications involved. As I push, she becomes quite defensive: 'It was at the end of the placement that I had seven patients, so I had an overview ... it may sound arrogant ... but I knew what was going on. It wasn't standard to have seven patients, it was an exceptional situation' (04-L17.59/04-L18.13). I'm still not quite satisfied that I've uncovered as much as I can in understanding this balance between collegiality and responsibility, and then Linda starts talking again in a soft, almost hesitant voice: 'It is, indeed, about finding a balance. It's difficult to find ... it's about the patient, you and your colleagues ... you get pulled three ways ... it's a puzzle for me ...' (04-L18.49). Linda tells me how she only includes herself in the puzzle sometimes – she works from routines and the things she knows, but finds this unsatisfying: 'So you stay in a circle, with fewer patients – not more than five – you can do extra things like discuss the nursing care plan ... but I only do this at clear moments (when I think about my learning process)' (04-L19.22/05-L19.58). Linda explains that the most beneficial discussions have been those with her practice educator because 'she views things differently; from outside ... she has more time. The mentor finds that it's all going well, but then keeps pushing you in the same direction ... they're blinkered' (04-L20.51/04-L21.20/04-L21.42).

Linda refers back to a valuable discussion with the practice educator in which they addressed the psychosocial care for a patient from a theoretical perspective. From the way Linda explains it, I get the strong impression that she is unable to apply theory learned in the classroom to a patient admitted to the ward for two days. Based on what she tells me, Linda doesn't seem able to think further than discussing the issue of social isolation with family members. She identifies the patient's problem, but isn't able to take it further in practice – also partly because her mentor has no time for this type of discussion.

Linda values the time spent in discussion with the practice educator; however, she also admits that it is an interesting, but theoretical discussion: 'In general my care hasn't changed – I find it interesting to talk about it. The added value



is the discussion; I've been able to talk about care at a social level ... I don't do anything extra with it in practice because I already work with the social aspects of the patient' (04-L22.27/04-L23.07/04-L24.01/04-L25.45).

I'm still not clear on what the added value of such a discussion with the practice educator is, if not to change the way a student works in practice:

'By talking about things and not only thinking I can move on with things and break the circle. I learn from writing critical incident reports and from talking with you – this is also a sort of reflection. That way I move on with my thinking, otherwise I just stay in a circle' (04-L26.34/04-L27.41).

But Linda also explains how important a named mentor is on the ward and illustrates this by telling of how during a duty, on Ward F, her mentors had been switched and her new mentor hadn't had time to read her patients' dossiers and how dramatic this was when one of her patients had a bad turn and she wasn't able to find support (04-L10.19/04-L11.05). From this potentially life-threatening situation Linda again draws a moment of learning: 'I must know what I need to do and so read the dossiers (before starting) – I must know what has happened to the patient. The things I do can be dangerous for the patient' (04-L11.16). 'I need to insist that my mentor reads my patients' dossiers and make arrangements in the morning for (help during) the rest of the duty.' Linda laughs: 'I'm getting very strict. ...' but then says, softly, '... there could have been mistakes ...' (04-L12.56/04-L13.11).

Linda remains enthusiastic about her interaction and communication with patients. She finds it interesting how people cope differently with situations and is enthusiastic about developing her contact and trying to understand the patient's experience (04-L07.16). She uses this insight to develop the relationship further (04-L07.28). Although she's not enjoying her current placement in mental health, Linda has witnessed the importance of a two-way relationship between nurse and patient and how that strengthens the bond: 'I want to take this forward' (04-L07.38). 'My goal is to interact with someone. If you don't know what's wrong, there can be no contact and that influences your care' (04-08.25).

Linda is now midway through the nursing programme and I ask what she feels her most important development has been to date. 'There are days when I



come home from the hospital and think: what a fantastic profession I've chosen.' (04-L50.59).

'As a person I'm more independent. I enjoy working with people' (04-L49.30) 'and I'm happy' (04-L50.00). She refers to the workshop we did at the beginning of the programme in which she had chosen the photograph of a boy with a cello between his legs and his arms held wide: 'Dadaah.' she trumpets, 'I've made it. I'm not bound by structure.' (04-L50.20) 'The cello is the profession and the boy is radiantly happy – so am I in the hospital ... but not in the mental health placement, although communication with dementia patients is wonderful ... trying to find out what makes them tick' (04-L51.52).

This is clearly how Linda feels in her new profession. Her verbal and non-verbal communication say it all and her 'freedom' is an issue that she returns to at great length two years later during our final interview. She loves the shift-work and the freedom it allows by not being stuck in a fixed week routine. She's enthusiastic as she tells me how she fought to collect money from outstanding debts in her previous job and that she now fights for people (04-L51.40).

'I've experienced so much this past year. I'm trying to become more assertive ... taking shaky little steps, but it provides hope for the future. I've got my self-confidence, and now I must become more assertive' (04-L53.07). Linda gets feedback from her friends that she has an aura of self-confidence even though she's 'having a difficult personal time' (04-L53.59).

Two years on and Linda would explain that her long-term relationship was breaking down at this time. At the time of this interview I didn't fully understand what Linda meant when she told me that the first year had 'not been easy' – hearing this again in the context of the final interview and Linda's description of coming out of the 'black hole' makes a lot more sense to me now. She goes on to say: 'The profession was motivating enough to make me fight and carry on' (04-L54.30). 'It's an undiscovered world, I try and it evolves ... to see that I can be a social (socially conscious) person means that I'm discovering a whole new side to me ... it's a development' (04-L55.21)

November 2004:

I decide to meet with Linda again in 2004 to see how she's dealing with the move back to the general hospital after her mental health placement. Her secondment is the first topic Linda brings up: 'I found the mental health



placement terrible. I was so pleased to be back in the general hospital and able to use my brains again ... to be able to think. There's a big difference between mental health and general nursing' (04-L01.11).

Linda had her mental health placement on a residential unit for Alzheimer patients and was able to identify learning objectives during the placement, but was clearly pleased to move on back to the general nursing environment she'd originally chosen.

Linda goes on to say how scary she found her time on Ward F prior to spending 10 weeks away on her mental health placement. To add to her angst, she witnessed a patient's resuscitation a half-hour after reporting for duty after the mental health placement. (04-L04.48). This experience, although beneficial to see, didn't immediately remedy her angst as it seemed to be very chaotic; but at the end of the placement she was more relaxed and wasn't afraid of everything that could happen to patients on the ward: 'It was a nice feeling that I wasn't so stressed anymore' (04-L01.38).

Linda is clear that the turning point came when she'd worked a few times with a very good mentor who interacted well with the patients – there was no panic: '... stress is contagious ... if there's panic, I get it too ... everything must happen quickly'. She learned from this mentor that it wasn't necessary to panic: '... just do things quietly and the patient stays quiet too ... you've got to do things quickly, but you've got time to think ... it took quite some time before I understood that' (04-L02.58).

At the end of the placement on Ward F Linda was confident on the ward, but then she transferred to Ward G: 'I was very uncertain again – I didn't know where my boundaries were and I didn't know the protocols' (04-L02.01). Initially on this ward, Linda felt very insecure and was allocated to night-duty after two weeks on the ward. In this situation she was confronted by her lack of competency in skills specific to surgical wards – traction, catheterisation and intramuscular injections. This was a confronting and unpleasant time and numerous procedures had to be negotiated with the registered colleague also on night-duty (04-L07.23). Confrontation with feelings of incompetence made it essential that Linda establish her boundaries within a new context of care (04-L09.43) – she is confident as she recounts: 'Things are fine now. I need to be clear – unknown boundaries make me uncertain ... I need to feel in control ... a bit of a control freak ...,' she says with a giggle, '... and then I can work well' (04-L10.30).



I'm feeling quite overwhelmed at the difference in our discussion as compared to our previous meetings. It seems to me that in the previous meetings Linda was aware of her responsibility and it seemed to weigh heavily on her shoulders – she was very nervous about carrying the burden of responsibility. Now, however, she seems to know her responsibility but seems able to state clearly what she needs in order to be responsible. To me, she seems to have taken on a more proactive approach. Linda: 'More experience and more knowledge means that you can carry more responsibility ... too little knowledge makes me uncertain' (04-L11.07).

I'm curious whether Linda perceives pressure to take on more responsibility than she can actually cope with – I ask her if, in her opinion, there's tangible hierarchy on the ward.

'There's a difference between people ... age and work experience – the longer someone has been on a ward the more say and a louder voice they have. I feel that there's a lot of loud shouting and complaining ... sometimes it's appropriate ...' (04-L13.43). Linda tells how the older nurses on the ward attempt to influence the younger nurses on the ward to voice their opinions with regard to proposed changes on the ward.

The hierarchy on Ward G, although clearly present, seems more social and not necessarily in the line management (04-L17.04/04-L17.52). On Linda's previous ward, the registered staff all seemed to have the same status, but there was more of a division between registered staff and students (04-L18.14).

From Linda's perspective there is a difference between nursing students depending on how they work. She tells of two students on the ward at present. One is alert, sociable and works well and Linda experiences no difference in their levels. The other student comes across as being timid, is less communicative and doesn't actively look for learning opportunities and Linda is aware that she responds differently to her ... her approach to this student is 'more dominant' ... 'I feel equal to the active student, but feel I'm "above" the other one' (04-L19.00).

Linda's approach to the different students appears to be related to the way they present themselves within the team. I'm curious whether Linda's persona on the ward mirrors her perception of the students she's telling me about.



Linda tells about her approach to her colleagues; she has developed a tactic in her communication: 'I straighten my back and square my shoulders ... I try to come across as being strong and serious ... I take on an attitude – a confident attitude. Maybe I feel uncertain, but I say so in a strong way so that people can't overrule me ... make me feel small because I have a question – I don't have to be ashamed that I don't know something. I don't want to be pushed into a corner' (04-L21.03).

Linda explains that as a student you have a choice: either work independently or do everything under supervision. This is an important choice as, once you've decided, you're 'stuck'. The student has 'established an image' for themselves which is then difficult to change. She's very clear that, as a student, it's important to keep communication open and regularly realign boundaries, setting a personal course for development. She adds: 'Quite often you're not pressurised (by others), but you pressurise yourself and steer the situation' (04-L38.44). 'It's important that I feel free. If I get swallowed up, I can't offer help – I must be able to free myself from my own patients to be able to ask and offer help ... it gives me more of an overview' (04-L40.52).

I am a little taken aback by Linda's confession. This feels like a hierarchical, power-related approach and I'm intrigued at the underpinning reasons behind Linda's developing this attitude. Randle (2003a) suggests that students who are caught in a conflict between their personal philosophy and loyalty to registered staff but who continue with their nursing education and do not drop out of the programme assume the role models they have seen and take on a position of power over vulnerable groups, namely junior nurses and patients. I find it difficult to believe that Linda would assume a position of power over a junior nurse. She claims that she feels 'comfortable with this approach', but then goes on to say that she believes that 'with age you have a right to be taken seriously' (04-L22.20) – it's apparent that she falls back on her age and previous work experience as a construction engineer and clearly feels she has earned respect. In response to my question whether attack is the best form of defence in this case, it's now Linda's turn to be taken aback: 'It's not an attacking attitude, but one of 'here I am'. I'm demanding equality and want to be seen as full (an adult) and it (asking questions) doesn't detract from whom I am ... I think my attitude is open' (04-L23.35). Linda thinks her approach has to do with her experience on Ward E, where she felt at home quite quickly and so dared to fill the space (04-L26.04). On Ward G she also felt at home very quickly and so was comfortable to assume an attitude on the ward; possibly this was due to the specialisation on Ward G being less complex than Ward F, which gave her more



self-confidence (04-L26.37). I find myself wondering if and what the difference is between power and assertiveness – I suppose one man's freedom is another's oppression ...

Linda still maintains that the more protocols are used on a ward, the easier it is to take extra responsibility as they provide clarity of routine and it is easier for a student to set boundaries. There are, however, times when an unexpected situation arises with a patient putting Linda out of her depth and comfort zone. Whereas before she would accept the workload without questioning, she now sees it as a challenge and usually manages to cope. Coping with a complex workload does not, however, give Linda the satisfaction she otherwise gets from having personal contact with the patient: 'I want to be able to do it (cope) and if someone offers to take on some of my work, I'm resistant 'cause I want to do it myself' (04-L28.41). Another aspect Linda takes into account is that if she's allocated a number of patients on a shift, then that is, she feels, what the team expects her to manage (04-L33.38).

I'm fascinated as Linda continues to tell me that the team on Ward G is very collegial and communicative and the ward staff pull together to get the work done: 'here you're allocated your patients, but then it's discussed who has time to take any new admissions' (04-L37.13). Ward E was different: 'there was far less team spirit' (04-L32.33), a more individualistic approach: 'everyone had their own plan' (04-L36.49/04-L37.56) and Linda felt pressurised to take a full complement of patients (04-L33.30): 'you were just allocated bays and were expected to do the admissions planned for the day too' (04-L36.49).

'I enjoy my work – it gives me energy when I work with people ... I need it. It (nursing) makes me happy and I get something back' (04-L42.02).

There have been different issues that have caused Linda's personal development – the state of burn-out she was in when she started the programme, her relationship, the change in career move from construction engineer to nursing, the freedom of shift work, working with people rather than finances and the value she perceives from the work she's doing: 'If I hadn't been in the black hole to start with, I wouldn't be here now' (04-L43.17). Linda tells me that her confident attitude has to do with the fact that she's come to our meeting straight from the ward – that's why she's so happy. She would have presented differently had she had days off prior to our meeting (04-L47.35). She is happy with her work and feels proud and



enthusiastic that the hospital was elected one of the top hospitals in the country (04-L48.50).

Linda is radiant and oozes self-confidence. She has a completely different presence than during previous interviews. I'm very impressed at the different perspective she has on responsibility and her proactive role in dealing with it.

December 2005:

It's been a year since Linda and I last met. The first thing she tells me is that she's very happy and feels good (05-L01.28). This feeling of happiness has to do with working shifts and having the feeling that she is free in her work (05-L01.48); she ends by saying that she never – at least not now – wants to work office hours again (05-L03.29).

Linda's becoming more aware of her role as a nurse. In discussing her work with non-nurses she is surprised at the physical, social and emotional efforts with patients and colleagues she expends during a shift: 'You're managing (situations) all day ... sometimes I first have to rest before I can be active in my private life – during the day I've blocked out my own feelings and I'm only aware of it when I'm away from the ward and tell someone about it' (05-L57.08).

When we last spoke, Linda was doing a placement on Ward G and tells that she reached a time that she was 'finished with the specialisation': 'it was boring and, at times, quite heavy physically ... you were constantly having to fetch and carry bedpans' (05-L05.25).

Ward H was different and Linda needed time to adjust to the ward. The team was very direct and that was difficult to deal with at first as Linda didn't feel free enough to be direct in her communication. Linda has criticism of the communication style within the team – small things she forgot to do – clean a patient's locker – were (in her opinion) blown up out of all proportion and the registered colleague who had the criticism didn't give Linda direct feedback, but reported it to her named mentor and wrote a short report to be discussed in the mentor's evaluation meeting. This was a turning point for Linda and she decided to give the team feedback on the way they gave the students feedback: '... this was a very conscious decision and it was good – it was a turning point' (05-L06.31). 'I HAD to give feedback; otherwise I wouldn't be true to myself. It was a good experience and I keep having new experiences –



my self-confidence is growing and I feel strong (due to the experiences) – it's completely new behaviour' (05-L08.50). 'I communicated back to them in the same way that they communicated with me ... I call it "active experimentation" (laughs) – like for like ... you use the same direct method of communication and you're respected' (05-L55.19). Although unpleasant, she feels that in dealing with the situation on Ward H her self-confidence increased and she started her new placement on Ward I in a different, more confident, frame of mind (05-L56.17).

Linda tells that she'd given feedback prior to this situation, but possibly not as consciously: 'I'm now really aware of my boundaries and what I want ... I'm not going to allow them (the boundaries) to be crossed ... maybe I come across sometimes as arrogant, but I can justify it (my decision)' (05-L09.30).

The new-found strength and confidence has partly to do with the lessons Linda's had during the programme on communication, but she feels it depends on who she needs to deal with: 'There are good and bad examples ... I learn from X (names a fellow student), she's very assertive and I see her as an example' (05-L10.23).

Linda tells that she's surfaced from the black hole of being burnt out in her previous work and the resultant breakdown she suffered, and the more recent breakdown of her long-term relationship. She goes on to say how she realised that she had needed to find herself again: 'I'm conscious that I'm developing ... before that I sort of stood still for a while – I dare more now and experiment with behaviour' (05-L08.01). Linda feels that her relationship breaking down had more to do with the fact that she was in a state of emotional crisis rather than her development through the programme (05-L-11.17).

Linda tells that she'd always been a happy person, but had lost this characteristic in the 'long history' leading to her breakdown as she slowly sank into a black hole of burn-out. She's enthusiastic about her personal development and has heard from her social network that she's back to how she was before: 'I have more baggage (knowledge and skills) now – I'm more assertive now, but it's not really a new behaviour for me, but more the old me' (05-L12.06).



Linda agrees that she now carries her responsibility with her and is not frightened of it anymore. We talk of the difference I see between her attitude to responsibility now and when she was on Ward F more than a year previously: 'It's because I have more knowledge, skills and experience ... I was not competent enough to carry the responsibility on this ward – perhaps it wasn't expected of me, but that's how I experienced it' (05-L14.20).

Linda reflects on her feelings of panic on Ward F when she felt out of her depth when confronted with an acute and unexpected situation with a patient. She identifies with the feeling she had then and relates it to a recent situation during a night duty on Ward I in which she was confronted by an acute situation and again became panic stricken. Her dexterity disappears in an acute situation and she seems unable to carry out quite basic skills: 'I want to be able to do it, but I just can't' (05-L15.15/05-L21.03). The common denominator leading to the panic situations in both situations is that Linda wasn't given an induction on the ward. She tells that she made sure that she had inductions for a while after the first situation on Ward F, but this seems to have slackened off again. On Ward I, she'd gone to the cupboard where apparatus was kept as a standard on all the previous wards, but when it wasn't there she became panic-stricken – it was locked away in a cupboard at the secretary's post – an illogical choice as far as she was concerned (05-L22.08/05-L23.21). In this situation Linda seems to take the responsibility personally: 'I feel as though I fail, but due to the panicky instructions I get panicky too' (05-L21.58).

She is honest in that she didn't have an overview of the situation and, as it was the first time she had her 'own' patients during a night duty on the new ward, she didn't know what to expect or what she might have needed besides the most basic things to deal with a patient experiencing a massive bleed. In retrospect, the patient Linda refers to had been sent to the ward due to an incorrect assessment in the Accident & Emergency Unit. As it was, the patient turned out to be unmanageable on a routine ward and was transferred to the Intensive Care Unit (05-L24.55).

We discuss the situation further and Linda concludes that when she's confronted by a life-and-death situation she goes to pieces – dealing with this type of situation is the experience she needs to develop (05-L18.18). It's not all panic for Linda, though: – she's clear about her boundaries: 'You have to recognise your boundaries and what you can do for the patient and what you're able to do (within your set of competencies) – you must know that' (05-18.41). Linda relates the discussion on boundaries to what she considers to be professional practice: 'Not only medical things such as understanding the illnesses and medicines, or the physical care for patients using the nursing skills you have, but it's



also the psychological ... you have to be open to that too' (05-L27.51). 'I hope to keep developing after I'm qualified ... a lot has to do with my personal development, but it goes further' (05-L29.01).

Linda has decided to use her final assignment to investigate the patient's experience of hospitalisation in the context of general hospital routine. Based on her holistic view of the patient she wants to explore the influence of activity and recreation on the patient's healing and perception of well-being (05-L29.46): 'I've already done a bit of background work and asked the patients ... they want to feel useful and not only be a patient ... they sometimes really want to help you to make up a bed' (05-L30.47).

We refer back to the focus group interview we had in 2003 in which the focus of the discussion was on doing small things for patients. Linda remains true to her ideas at the time that it's important to do little things for patients, but is also realistic that she has too little time actually to take patients for walks and outings to the park as had been the suggestion in the previous discussion (05-L32.03/05-L32.26/05-L34.05).

I challenge Linda in her holistic approach: to what degree is it a lip service she's providing if the somatic care and emotional crises are the priority rather than a proactive approach to prevent the patient decompensating? (05-L32.26/05-L34.05/05-L36.58/05-L38.31).

I am thrilled when Linda squares her shoulders and argues her prioritisation, providing me with an insight into her social contact with the patient and how she uses herself as an instrument to provide a feeling of well-being: 'I introduce myself to the patient and must see the patient after I've read the dossiers – I must have an image of the patient. I love humour and so suss out if the patient likes it too ... I try to get people to feel freer and it creates a bond with other patients if you have fun with them. I try and discern which patients are feeling withdrawn and which have pain or are feeling sick. I use the patient interaction to build a good atmosphere – I'm part of the ward. I try to get to the underlying stream with the patient and sometimes you need a joke, but not always ... I always manage time to give attention to the social side of things with the patient' (05-L38.31/05-L39.20/05-L40.09/05-L41.40/05-L44.38/05-L46.56/05-L48.36).

Linda has moved on from withdrawing when feeling uncertain in a situation to opening a discussion with the team during coffee or lunch breaks to ask advice or pose questions: 'That is the beauty of a team, to learn from each



other. I'm not afraid to be confronted by a situation anymore – the team is important to make you feel supported' (05-L50.33) '... but the team is also able to push you over or under' (05-L53.09).

Reflection and supervision are beneficial and allow Linda to think about how to deal with similar situations in the future (05-L10.01.24).

June 2006:

Linda is enthusiastic about the programme: 'It's been life-enriching' (06-L10.06). Linda feels that there's something to learn from most things – 'even unpleasant things.' She's thinks about things and tries to learn something from each situation, but also feels that there are some things you can't learn from ('which' she adds 'is itself a moment of learning. To learn that you can't learn from everything'), in which case she doesn't become weighed down by it, but leaves the situation behind (06-L10.20/06-L23.17): 'Naturally I've experienced unpleasant or shocking things ... I take them with me, learn from them ... I don't deal with them superficially, but it also doesn't hold me back' (06-L10.43).

Linda believes strongly in an element of predestination. She has been sent down this winding path, so 'go with the flow'. Linda tells how going with the flow has also provided her with a sense of freedom – she has learned that she has to follow her feelings (intuition): 'I was quite restricted and controlled but now I'm freer – that gives me freedom' ... 'go with the flow' ... somewhere deep inside you you know what you want/where you're going; by forcing it, it won't work' (06-L11.55) '... if you force it, things get very heavy, but you also don't end up where you're supposed to' (06-L12.40). 'I don't know where I'm going, but there is somewhere I'm going ... I'm sort of predestined for something, but it sounds heavier than how I feel it' (06-L13.10). Linda explains how she feels that some things don't happen by coincidence, but that it's important to let them wash over you and do something with them and see what happens: 'I feel that I'm going somewhere ... not a *place*, but *being*' (06-L13.31). 'There's been a big change before and after the black hole' (06-L14.16).

Linda's feeling of predestination is not related to a form of religious calling, but she does think that the way she was raised influenced the way she thinks, but 'I don't see caring for others in terms of heaven and hell ... I don't have a halo.', she ends with a laugh (06-L24.31).



At the moment Linda's destination is leading her to the period of voluntary work in Africa. She's enthusiastic about getting involved in work in a developing country, but needs a certificate in tropical medicine, so she wants to do a period of voluntary work as a taster. But then she's seriously considering a tropical medicine course and/or an Intensive Care Specialisation (06-L33.29/06-L33.40).

We talk about Linda's work satisfaction. This, she tells me, is about being socially conscious and the interaction between people: 'Not only giving, but receiving too' (06-L16.53). Linda explains how she strives for the appropriate interaction; not to stand 'above' people, but to be interested in what other people think and do ... especially older people: 'how they look at life ... with a lot of humour, but also deeper – I find it beautiful, but there must be interaction' (06-L17.05). Linda goes on to say how she thinks it's important to have (nursing) skills to use in a crisis situation, but the bottom line is about interaction.

I'm curious about what Linda feels she gets from her relationship with her patient. She explains how important she finds the personal bond with someone: 'you must form a bond with someone, otherwise there's role hierarchy' and adds: 'there are so many different types of person – you can learn from them.' ... 'My challenge is to break through the (nurse/patient) role and create equality as far as you can' (06-L18.06).

Linda is aware that people share parts of themselves with her as a nurse and they can, at times, be 'deep things'. 'The elderly have their lives behind them, but went through the same things as me ... I look up to them with respect and put them on a pedestal, but through interaction (communication) you discover that they went through the same things and that we have commonalities. I find that beautiful and it gives me (a sense of) satisfaction' (06-L19.42).

Linda's final assignment on patient hospitalisation links directly to her ideas of equality in communication, and maintaining the balance between doing everything for a patient and expecting them to be totally independent while they're admitted to hospital. She's clear in her approach that a patient needs to learn to be independent: '... otherwise they stay in the sick role if you do everything for them ... of course it's nice to be spoiled, but you ultimately can't escape from it (the sick role) (if the patient isn't stimulated to be independent)' (06-L26.09).



Linda has seen extremes among nursing colleagues with regard to their expectations of patient independence in a general hospital. She is of the opinion that patients who are confronted by different expectations lose their identities and adapt to the situation by developing a passive role as they don't know what's expected of them (06-L28.18).

An important challenge Linda had to deal with was related to patient confidentiality and secrecy – a true dilemma for her as it involved a confrontation with a good friend. Linda realised that painful situations have to be dealt with, they don't disappear spontaneously and she couldn't hide behind a wall. Communication was the only way of resolving the situation (06-L35.40/06-L40.17).

Linda has told me numerous times that the discussions we have during the interviews are beneficial. Issues are raised and discussed and we have the time to discuss things in depth. She finds it valuable when I challenge her way of thinking and give her a different viewpoint – it gives her something to think about. Reflection and critical incident reports are important learning mechanisms for her (04-L49.28).

I'm aware that I've moved on from where I was in wanting to 'use' the students to make my own point; nevertheless, I feel very satisfied with this feedback. I find that I'm questioning whether there is a difference between supervisory and reflective sessions and research. I question whether (qualitative) research is solely based on the researcher's wanting to understand more about a situation, or whether part of the researcher's motivation is also to promote awareness among the participants. Could it be that researcher and participant choose to be together in a common process because both parties want to learn and become aware of 'invisible' forces driving them? Some would say there is no coincidence; choosing to expose and be exposed in search of a common goal. Why, out of all the cohort members, did precisely these five students agree to work with me on my research? Is my identification with Linda the resonance with her belief of predestination? Have I become too involved with my participants to be a 'true' researcher? Peter is asking questions again.

I don't think so. I am becoming more convinced that it's impossible to be uninvolved at a personal level in one's research – I do believe that objectivity is an illusion. The fact that we see and hear things from any research data – be it qualitative or quantitative – makes the process subjective. I can't believe there's any other way of being. The only validity I



can provide is transparency and try to separate my issues from those of the participant. If I fail to do that, I not only invalidate my research, but also do not acknowledge those willing to work with me and do not treat them with the respect and integrity they deserve.



## **SECTION SEVEN**

### **Marijke's colourful focus**



### **Marijke's colourful focus**

'So many colours ... they fit together with personality ... I'm a colourful person. A joker, but also someone you can come to for a serious talk. Two different characteristics and so two different colours' (06-M12.58). 'The line is A to B, straight ... that's the way I see it ... focused ... I want to complete the programme. A clear beginning, a clear end goal – get my diploma' (06-M20.30).

'This is me at the beginning,' says Marijke, pointing to the dark green dot she'd drawn on the right-hand side of the page. 'I was green, just beginning ... but not green in nursing as I'd done level 4. ... And this is me ...' pointing at the purple dot, 'full now ... including emotions, feelings, experience and ideas that have grown and happened' (06-M00.51).

'The beginning was vague and cold ... a vague red line' (06-M01.26). Marijke tells how, in the beginning of the programme, there were so many things happening to her that her propedeutical phase<sup>5</sup> was at risk and she had to rush the assignments at the last minute. All this made the future seem vague.

Marijke struggled to find herself and her place; she couldn't 'be herself'. On the ward 'I didn't really ... well I had an idea of that's where I wanted to be ...' but she was aware that she couldn't yet reach that ideal due to her lack of experience and knowledge. 'I was very insecure because of my achievements at school' (06-M01.48).



### *Marijke's colourful focus*

<sup>5</sup> First year of the four-year Bachelor's degree at universities in The Netherlands.



'The yellow here, that's sunshine. I enjoyed my first and second placements, and I went to Scotland (for an elective placement in mental health). I needed the break to get out of a negative drag. I loved it. My little ray of sunshine.' (06-M02.26).

'Brown ... (roughly halfway) that was the point of my knee operation and the traumatic experience I had (Marijke had witnessed a fatal accident) – both had a big impact on me' (06-M03.15).

'The red line is getting clearer' (06-M03.25).

'The blue and green – that's the coldness of Ward B. A cold ward that doesn't fit with me. But it was good ... I could learn exactly – because it's the exact opposite of me – who I wanted to be ... with lots of feeling and lots of love. That's why I used red – it was clear. I realised what I missed ... so I became the nurse I wanted to be from the beginning' (06-M03.40). Marijke felt strengthened through her experience on the ward (06-M12.27).

'The end is very light, full of passion, love, dedication and happiness. This is who I am. On this ward I can be completely myself. I'm appreciated by my colleagues and I feel great.' (06-M04.34).

'Purple – that's my colour when I feel great' (06-M05.08). 'Red and blue – they give me balance' (06-M05.19). Towards the end of our meeting Marijke returns to seeing herself as the purple dot: 'Complete ... and looking towards the future ...' (06-M31.49).

Marijke falls quiet after explaining her colours, then looks at me ... 'I'm surprised at myself,' she says quietly (06-M05.27). At the end of our meeting Marijke comes back to this point: 'I'm amazed at myself that I've just blabbed it all out like this. I'd almost forgotten about our appointment today, so wasn't able to think about things ahead of time. So I've just thrown it all out there. Our talks have contributed to that' (06-M38.38).

Symbolising the first half of the programme, Marijke's drawing contains many colours, while in the second half, although it's warmer, there are fewer, but brighter and stronger colours. Marijke feels this has to do with the fact that in the beginning there were so many external impulses, but also so many impulses from within that she didn't feel in



control. Now it is different, she feels she has a grip and is more in control of things' ... 'that's why there's purple – I find it a total (complete) colour' (06-M13.41).

Marijke felt quite overwhelmed to begin with, moving to a large city for the first time and starting work in a large general hospital. Both these major changes created a huge number of stimuli. This was compounded by, according to Marijke, the fact that she has a large number of personal characteristics: 'In the beginning I was all over the place ... I didn't know what I liked or wanted or how my emotions worked' (06-M15.44). But now, four years later, things are different: 'As a person I'm more stable – it has to do with the things I've experienced in my personal life ... I've grown stronger' (06-M16.45).

Marijke experienced a major turning point in her life midway through the programme – first, owing to problems she had with her knee, it was uncertain whether she'd be able to complete the programme; secondly, her relationship with her partner took on a permanence and they moved in together; and, thirdly, she witnessed a fatal accident (06-M17.26). These three things all happened within a relatively short time of one another and, needing five months to recuperate from her knee operation, prompted Marijke to reflect on her emotions and how she was perceiving life. At this point the red line in her drawing becomes clear and bright. I ask whether the colour red could also possibly relate to anger – Marijke is adamant that it's the colour from her heart symbolising passion for what she needs to do (06-M18.12)

At times the programme was a survival course, such as her placement on Ward B. But mostly the placements were not problematic – the academic side was more of a problem. Marijke had somewhat of a last-minute strategy, but managed to pass everything. This seemed to come together for her on the Ward B placement, during which she made a conscious effort to focus on what she needed to achieve (06-M21.45).

December 2003:

Marijke is part of a focus group interview with two other students. The discussion has just started and is focusing on the students' doing 'small things' for patients. Marijke indicates that she finds it really nice to do something extra for the patient and gives an example of a patient waiting for a hospice placement. Once she'd finished her work she took the patient for a walk in the public park opposite the hospital: 'This woman was a COMPLETELY different woman. Completely. ... say with something so small.' (03-M61-63). Marijke gives a more recent example of how she had given a patient with early signs of dementia a box with the pieces of two jigsaw puzzles and tells



how the patient kept herself occupied for the rest of the day sorting the pieces (03-M64-68). Although she feels that she has the ability inside her to provide this kind of care, she refers to her experience in working with learning disability clients prior to starting the programme in which activities were the most important interventions (03-M77-80).

Personal experience has also played an important role in formulating Marijke's view that it is important to provide the patient with stimuli – after a knee injury, she had a six-month period of bedrest and tells how she appreciated a car trip with her mother to do shopping: 'I found it did me a lot of good' (03-M99-102).

Marijke looks thoughtful: '... I think it's very difficult to maintain that, because I think that it's something you easily forget (to do the small things for patients), but I find I really like it' (03-M70). After a brief reflection she says: '... it's not really a standard thing ... you're more inclined to focus on bigger things. Because you're always busy you have to really think about it ... you have to maybe go to a bit more trouble to think of something' (03-M85-87).

The students' discussion is on 'doing small things' for the patient. They feel very strongly that this is where they need to focus their energy. However, the ward routines and activities seem to get in the way and the students seem to perceive a negative slant to the role of registered colleagues ...

The discussion moves on to the issue of students always being kept busy and so not having any extra time to do small things for patients. This creates a degree of irritation in the students. Marijke tells the group that she tries to discuss the fact that she wants to do 'extra things' for patients in 'good harmony' with her registered colleagues (03-M117) and tries to 'find a bit of a middle of the road method' (03-M208).

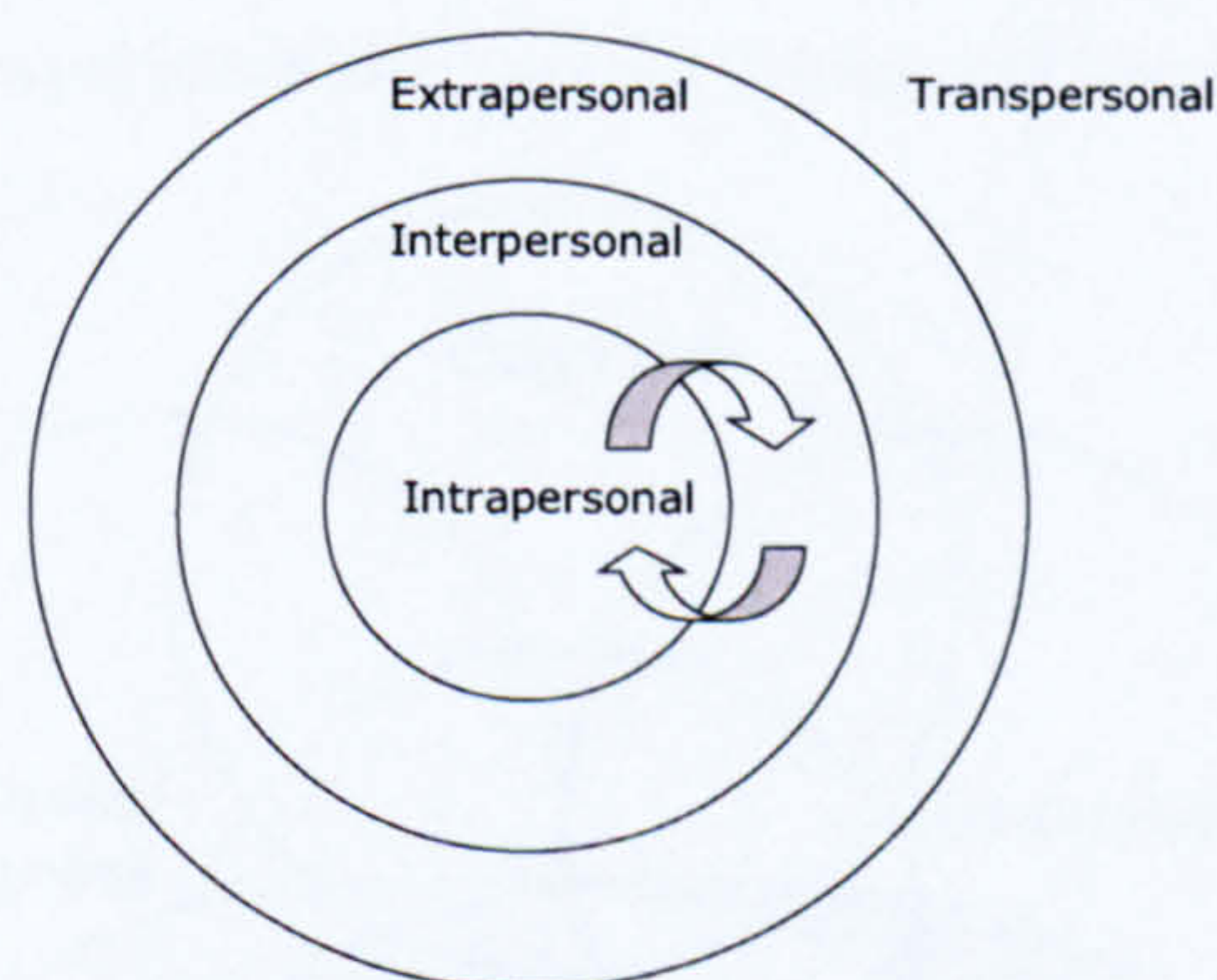
Marijke's reasoning is that 'extra things' are not really part of the planned nursing interventions and consequently doesn't really think they can be argued in terms of planned care (03-M222-225). Being too direct in her approach would result in resistance from her registered colleagues. By 'packaging' the message a bit more Marijke feels she could sell her ideas and that they would be accepted more readily (03-M249-250).



The packaging of messages described by Marijke is taken further during the discussion and the students identify that there is an invisible threshold that they need to cross prior to discussing things with their colleagues and mentors. After the discussion centring on 'being afraid' to discuss issues on the ward, Marijke suggests it has to do with collegiality and not wanting to provide her registered colleagues with extra work (03-M369/03-M374/03-M481).

Rather than refusing outright to administer an injection she hasn't witnessed being drawn up, she tries to make sure she's with the person preparing the dosage. In situations where Marijke feels incompetent or simply uncomfortable with the procedure she's been asked to carry out, she tends to apologise for her inexperience and assure her colleague that her inability is not anything of their doing (03-M382-386).

In terms of DeMeulle & D'Emidio-Caston (2003) (figure 7:1), I find this an interesting phenomenon as Marijke's interaction seems to bridge the intrapersonal domain (emotions, personal beliefs, creativity, values and thoughts) and the interpersonal domain (group dynamics, interpersonal communication and group leadership).



*Figure 7.1: Marijke's learning process (December 2003) illustrated in terms of the DeMeulle & D'Emidio-Caston (2003) model*

She appears to attempt to take on the responsibility that should be carried by the registered staff. Marijke's willingness to 'manipulate' her relationship with her colleagues became clear during our final meeting three years later when she told of her negative experience as a level-4 student just after she'd left school at the age of 16 or 17. This experience had a marked impact on her and her self-confidence. She was on a mental health placement at the time and was very enthusiastic at her choice of profession. Marijke doesn't tell the reason, but one of the registered staff was very blunt in saying

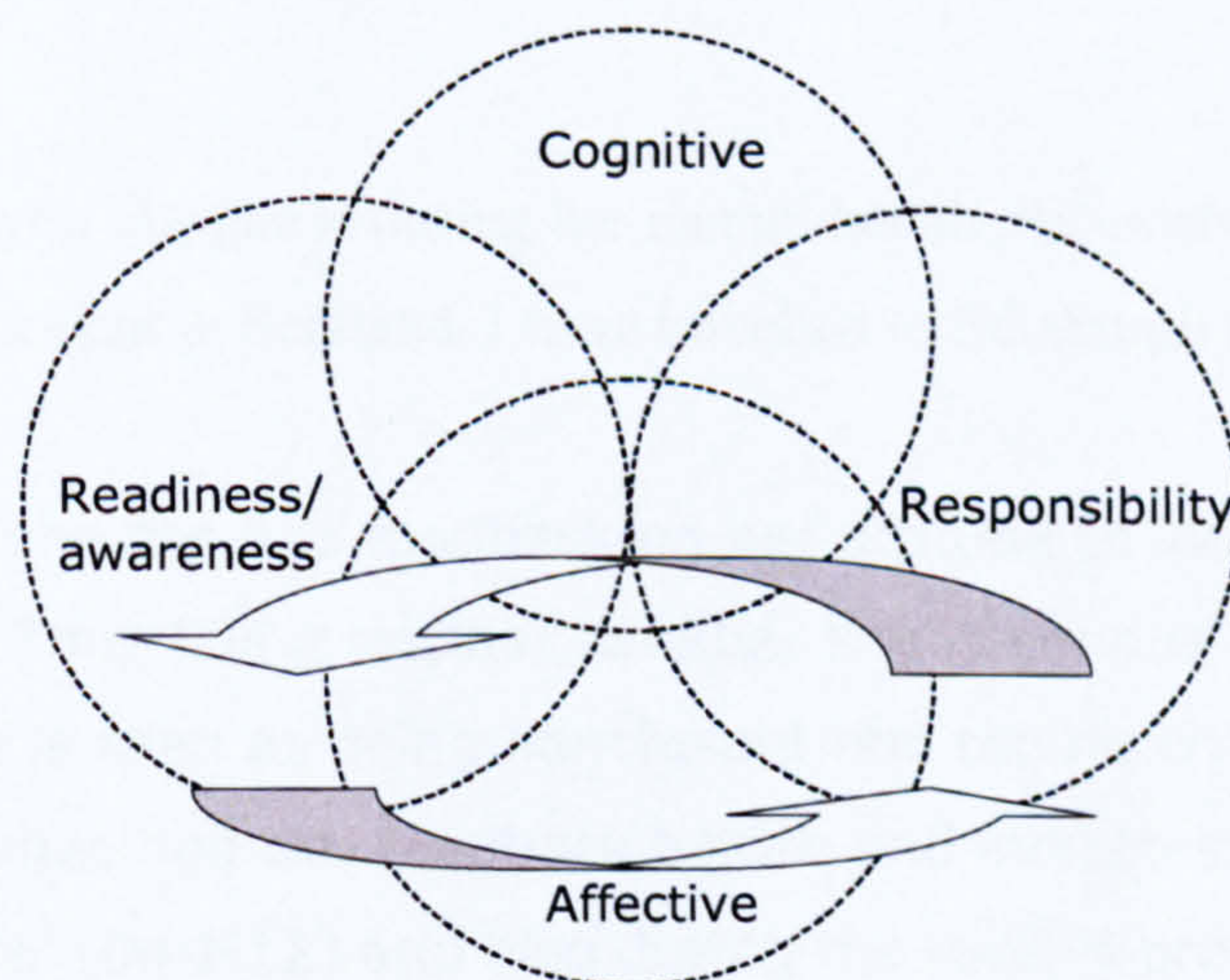


she'd have no chance in making a success of the programme in a general hospital when she wasn't even able to make it in a mental health setting. This experience highlighted her feelings of insecurity and lack of self-confidence and it clearly has a marked influence in her functioning now (06-M25.55).

It is, to me, common knowledge that, as nurses, professional boundaries prevent us from administering medication we haven't been able to check. I feel quite angry that the registered nurses seem to manipulate junior students into learning unprofessional behaviour. I'm quite sure that the staff concerned would not see the situation Marijke and the students have described as being a manifestation of their power, yet this is how it appears from my perspective.

Marijke tells that she has been proactive on the ward by including all the things she wants to learn in her learning objectives. She has also identified how she best wants to learn procedures – by watching, and then carrying them out a few times under supervision until both she and her mentor are happy with her progression. Only then does she execute the procedure independently (03-M622-624).

Hearing Marijke speak of how she's approached her placement, I can't help but think that she is using the placement experience she built up during her level-4 training.



*Figure 7.2: Marijke's learning process (December 2003) illustrated in terms of Castillo's (1974) model*

Marijke set her boundaries clearly right from the beginning of her placement (03-M621). She indicates that she is not afraid to ask for more time to learn a procedure and agrees to take the responsibility only when she feels



competent to carry it out (03-M624/03-M639) – in this respect ‘it’s gone very supplely’ (03-M632). Marijke tells how she discusses her needs at the start of each duty. Her mentors have given her positive feedback that she plans her supervision for the day ahead of time, which allows her mentors to adapt their planning accordingly: ‘That works well. It works well for me and my mentor is quite happy with it too’ (03-M641-644).

There are, however, moments when Marijke feels insecure and tends to ask a question that she already knows the answer to: ‘But then I still ... ask for extra time. I know it, but I’m not aware that I know it ... then I think: Gosh. Oh yes. I don’t need to ask that.’ (03-M692-693/03-M698).

In terms of Marijke’s learning process it seems to me that she is being led by what she perceives to be expectations of the ward staff (figure 7.2). Her care is based on an emotional approach to what she feels her responsibility to the patient is and attempts to achieve her plans by ‘manipulating’ her registered colleagues. She appears not to base her plans and decisions on professional arguments.

In a similar way Marijke appears to glean knowledge from her registered colleagues, staying within the affective domain, rather than gathering evidence-based information with which to challenge what she sees in practice.

June 2004:

My next interview with Marijke is during her mental health placement. She has chosen an elective foreign placement in Scotland. I have travelled to Edinburgh to interview her.

Marijke tells how she has had feedback on her attitude to learning from the college lecturers. They find it unclear whether she is serious enough for the programme – she is seen as being nonchalant and too much of a joker (04-M09-11). Marijke has had this feedback before and indicates that it ‘crops up throughout her life’ (04-M12) and also during the level-4 programme she’d been part of (04-M46-47).

At work she is different and tells that she has never had this form of feedback before: ‘On the ward I think it’s just the other way around; they first see my serious side, my motivated side and then my spontaneity’ (04-M140-141). She feels it’s important to share jokes with the patients, but that it’s equally important to ascertain whether it’s appropriate to the patient (04-M20-24). Marijke sees a big difference between learning at school or in practice –



patient care is more tangible and is where she feels more comfortable ... she becomes 'uneasy' from sitting in the classroom (04-M37-41).

This feedback on her attitude worries her as she doesn't want people to get the wrong impression of her (04-M14/04-M50-52/04-M125). Later she says that although she finds it 'difficult to hear, it's good to get a comment like that ... it keeps me sharp' (04-M53), but also accepts that others may have a perception of her as being a joker (04-M48/04-M64).

The feedback on her attitude is creating a dilemma for Marijke. On the one hand, she does not want to create the wrong impression of her attitude, but neither is she wanting to adapt her personality to suit the demands of others (04-M70-72/04-M91).

I'm curious and ask her whether she is playing a role to meet the demands of others. She's adamant this is not the case (04-M88) and assures me that inside her there is an 'unbelievably motivated serious part' that is coming 'progressively' to the fore (04-M89-91). She is afraid of playing a role as she feels that others will see through her and not take her seriously (04-M93). She also finds it important that others take the time to get to know her and understand what makes her tick (04-M97-99), but is also prepared to turn away from those who don't make the effort (04-M118-121). I'm aware that this discussion is important to Marijke and it's apparent that she identifies her own responsibility to show who she is: 'I am also aware that I don't show it 1, 2, 3 ... and as far as that goes there's a whole lot ... a big ... growth process for me' (04-M122-123).

During the discussion I ask Marijke how she's managing to cope with doing 'small things' for her patients – something she thought may be more difficult to achieve once she was further in the programme. She feels that on a surgical ward there 'seems even LESS chance to do the small things or ... to maintain it' (04-M160). The calibre of 'small things' has changed for Marijke; rather than taking patients for walks or playing games with them, she speaks to them (04-M163). She is aware that other nurses on the ward answer their personal e-mail rather than talking to the patients and finds this difficult to understand (04-M164-167). Marijke goes further to say that the nurses 'make it busy for themselves ... they're constantly busy with this and that ... if you continually complain that you're busy, you will be busy ... if you just accept that you're busy and get to work ... then I find it's not that bad' (04-M179-182).



My mind goes back to work by Walsh & Ford (1989) and Ford & Walsh (1994) as Marijke speaks – the continual busyness being the ward culture.

In talking about doing little things for the patients, Marijke comes to speak about the ward culture on the Ward J where she's placed at the moment. 'The people ... are fixated ... on the technical things ... are very task oriented ... can really be busy with tasks, tasks, tasks' (04-M201-203) ... 'everything must be done by 10 am' (04-M209). She identifies a difference with Ward H, where she'd done her first placement and where the attitude was 'more a case of "that must be done", but let's look how the patient's doing' and patient activities would be shifted to the afternoon if it was better for the patient (04-M207).

The nurses' subservience to the surgeons was another aspect of the surgical placement that Marijke was aware of (04-M228-229). Patient-related tasks had to be completed prior to the ward round – nurses who weren't ready for the surgeon would forfeit the patient being seen and any further treatment orders would not be made. This was a major issue for Marijke and she felt very strongly that patients should be made comfortable as well as being ready to see the surgeons (04-M234-238). Although she'd broached the issue with a number of registered colleagues, who agreed with her, none of the nurses in question felt in a position to discuss the patients' position and rights with the medical staff (04-M229/04-M245-247).

I find myself wondering about the leadership on the ward involved and try to imagine the strategies in dealing with what could amount to workplace bullying. Surely the health-care system should be moving away from a medically dominated and hierarchical paradigm if health care provision is to be brought into step with the 21st century? (Degeling & Carr, 2004) The more I consider the situation as I listen to Marijke, the more I think that the lack of support for a colleague is a form of horizontal violence – violence doesn't always have to be directed directly at an individual to be damaging. (Farrell, 2001)

For Marijke, another aspect of working on this surgical ward was the realisation that registered colleagues are judgemental about the patients and make humiliating jokes about them during hand-over. This was the first time she had experienced this on a ward and found it quite shocking. In one such instance she told colleagues about a patient's personal history which she'd heard about through talking to him (04-M263-283), but she didn't challenge



their behaviour: 'I find that difficult because ... I always think "she's still wet behind the ears" – she's trying to lecture us ... So I say something about it, but I'd like to say MORE about it' (04-M291-293). Marijke is aware that she 'disguises' her story so that it's less confronting to her colleagues (04-M306-308). She feels that a 'compromise' (04-M313) is better, because otherwise you have direct 'criticism of someone's attitude' (04-M333).

In her discussion on feedback to the ward staff it becomes apparent through her story that a lot has to do with the ward culture: 'I find very much on this ward that nurses really have an attitude of "I do it the best" and ... BEWARE ... if you say something about it.' (04-M335). She compares the situation to Ward H and feels she would have said something sooner because 'I felt more at home there and really had the feeling that they were more open for feedback than they are here ... and absolutely with regard to professional practice' (04-M337-339).

Marijke explains that her communication has improved through her being involved in my research and being challenged to think about things through my questioning. She has become aware of her attitude and how she feels as a student. As part of the programme the students are expected to write critical incident reports to help them develop their self-awareness – for Marijke, being subjected to the meetings with me 'gives just that extra point ... that you pay more attention to become more aware' (04-M446-451).

Distancing herself from the programme in The Netherlands has allowed Marijke to reflect on how much she wants to succeed – the battle she has to overcome the problems she has with her knee and the insecurity this has represented for the future (04-M463-465). The elective foreign placement has been a very positive experience for Marijke and has required her to be independent, has increased her self-confidence hugely (04-M460/04-M470/04-M474/04-M502): 'You must crawl out of your shell, otherwise you won't make it' (04-M262).

I'm curious whether Marijke feels there will come a moment at which she'll change her behaviour and challenge her registered colleagues. She's convinced that any behavioural change is part of the process she's in and feels that along the way she is learning to know her own attitude. Gaining experience gives her the right to talk and have an opinion (04-M350).



In a previous placement she would have thought about it, without saying anything and now she says it ‘in a packaged way’ (04-M357). Marijke identifies a change in her confidence, ‘that mentality-wise I’m different’ since her previous placement (04-M351/04-M358). An important aspect for Marijke is that she’s on a ward for a limited period of time and chooses to survive the experience rather than stick her neck out and challenge the status quo (04-M379). Although Marijke feels she can’t change the situation, she is aware that she is able to learn from the experience and tries to develop her own ideas as much as possible; but is clear that Ward J is not her kind of ward due to the ward culture (04-M382-386).

Marijke tells that she feels she has an ally in her allocated mentor on the ward who is in agreement that a surgical ward wouldn’t be the best choice for Marijke (04-M393-395) and she tends to agree with Marijke with regard to the team’s attitude and interaction (04-M399-401). Marijke is convinced it would be more difficult to accept feedback on her work if she had an allocated mentor who ‘places people into a box’ (04-M403). As it is, she only tends to get feedback on the way she carries out skills and procedures and none regarding her attitude (04-M412-415/04-M426-430). Marijke tells that she has set her learning objectives to suit the ward culture and that they are primarily focused on achieving practical goals, but that this allows her to set clear boundaries on a ward that may otherwise demand that she carry out skills she’s not competent in (04-417-419). Randle (2003a) discusses this perceived gap between actual and ideal levels of attainment and positive reinforcement from significant others. Randle suggests this has taken a negative turn and, in situations where education is seen to be distant and divorced from practice, students’ ‘loyalty’ to registered staff may come into conflict with the requirement to implement their knowledge and provide care based on their personal philosophy. This is apparently not a new phenomenon, as Wake (1987) has also suggested that nurses exhibit dual decision-making processes, namely patient-related and staff/organisation-related. I ask myself how student-centred learning objectives are if they’re led so strongly by the ward culture. And what does this say about a student who adapts so completely to their environment ... I question the role of the educator and mentor ... I assumed education was to introduce positive change into the profession ...

#### November 2004:

Later in the same year I decided to have another interview with Marijke as she’d since returned from her placement in Scotland. She had been out of action due to her knee operation and had the time to distance herself from the ward culture – I was curious how she viewed her situation from this vantage point.



Marijke has been away from the hospital for three months – part of that time was her elective placement in mental health at an institution in Scotland, and part has been spent recuperating from a knee operation. During this period Marijke was very unsure as to whether she'd be able to continue with the programme due to the physical limitations imposed by her knee (04-M00.57). Owing to the summer stop of hospital admissions, and the subsequent decrease in the number of patients being admitted, Marijke has been allocated to help on two surgical wards – J and I - for the summer months.

Marijke seems relaxed about working on the two wards simultaneously. I ask her about this.

The time in Scotland has clearly had a positive effect on Marijke. She tells how much more self-confident she's become – as though she's wearing a 'new jacket' (04-M01.20). She adds how this new-found confidence has to do with her seeking security with regard to her knee (04-M01.59) – if she's not assertive in protecting herself physically, she'll not be able to continue with the programme. This has become a source of great anxiety for her (04-M02.19). In part, Marijke's new-found assertiveness is linked to her work on the two wards. There is a difference in ward routines between the two wards and she has stipulated that, owing to the short period of eight weeks still to go on this placement, she finds it more practical to focus on one ward rather than learning the routines of both wards. This has been agreed upon in her learning contract (04-M02.33).

Marijke tells of how she needs to protect her personal boundaries as registered colleagues from both wards try to involve her in learning the routine skills and duties on both wards – medication distribution (04-M03.00) and nursing skills specific to each ward (04-M03.48). When approached to do night duty, Marijke agreed only if she was able to do the duties with her allocated mentor and argued this in terms of her agreed learning objectives (04-M04.04). Marijke seemed to be, indeed, showing a new side of herself – she was wanting clarity with regard to which nursing skills she was expected to execute (04-M04.40) and that she wanted 'lighter duties' to prevent herself over-exerting her operated knee (04-M04.49) – Marijke is convinced that, had it not been for her protecting her knee and having had a legitimate reason not to do heavy work (04-M05.12), she would have been pulled over her personal boundaries by the ward routines (04-M05.43).



Marijke is brimming with self-confidence as we speak – she’s aware of her confidence and is sure she’ll not adapt to ward culture quickly again (04-M13.52) – she adds that this insight developed during her time in Scotland. Her experience in Scotland definitely was a turning point in her developing self-confidence (04-M15.11), but this was also helped by the fact that her short placement on the surgical ward had gone well and there was no assessment involved (04-M16.43). Both these experiences had helped her in setting her boundaries in a new way (04-M17.58).

Marijke’s communication style has changed dramatically (04-M05.55). She is more direct in communicating her personal boundaries – an aspect that had, to date, been a point of attention. Again, from Marijke’s perspective, this has a direct link to her physical condition: ‘If I don’t do it now (set physical boundaries), I’ll have to stop (the programme)’ (04-M06.27). She had seen that setting boundaries worked during her time in Scotland and felt that if she could succeed in a foreign placement, she would have to succeed in her ‘own hospital’ (04-M06.48/04-M15.30).

Linked to her new communication technique, Marijke set her own conditions for the placement prior to asking the ward for theirs (04-M08.30). Coming into the placement after her experience in Scotland, Marijke found it relatively easy to create a ‘new’ image on the ward (04-M09.50).

She is the first to admit that her confidence wasn’t only to do with her experience, but because she was supported by the fact that this was a short placement (eight weeks, rather than 22) and there was to be no official assessment at the end (04-M11.00). This clearly reduced the pressure she would have otherwise felt and meant she could maintain her spontaneity (04-M10.08).

I’m curious as to how Marijke sees herself on the next ward – whether she feels she’ll be able to maintain this new image and communication style. A pensive Marijke doesn’t know, but doesn’t think she’ll adapt quickly to a new ward culture (04-M11.43-04-M12.18).

Marijke is apparently still impressed by the feedback she’d been given on her attitude and that others viewed her as not being serious with her studies – in this respect she feels she’s a changed woman (04-M12.05).



As part of the period of recuperation Marijke worked as the ward secretary so that she could reduce the burden on her leg (04-M18.11). This, too, was an experience that provided her with new insights into the dynamics of ward culture. Relationships with colleagues, whom she'd had problems with as a student, were now less tense (04-M18.41). Derogatory discussions about patients – that she had found unprofessional as a student – were now compounded with derogatory discussions about colleagues (04-M19.38). All manner of issues about colleagues were apparently discussed with the ward secretary – something Marijke hadn't been aware of before. Marijke was seeing the ward staff as shallow and fickle: '... I don't get it ... if I have an issue with someone, I speak to them directly and don't talk to someone else about them' (04-M22.05). 'I don't know what effect this will have on me for the next ward ... I would be distrustful if I had to work with these people as a nursing colleague, knowing what I know now' (04-M20.34).

When she started on the new ward after her recuperation, Marijke tells how she had discussions with her allocated mentor, educator and the senior nurse on the ward (04-M23.32) about her boundaries and learning objectives (04-M22.40). The discussions about her boundaries and learning objectives provided clarity and prevented her from being drawn into the hurly-burly of the ward (04-M25.07).

Marijke is determined to show that she is a serious student and feels that if her boundaries and learning objectives are clear and agreed she'll be able to be 'herself' on the ward (04-M26.07).

The communication and relationship between Marijke, her mentor, the educator and ward management are pivotal issues (04-M29.18) and Marijke feels that as long as her objectives and boundaries have been approved by this forum (those responsible for her assessment), the ward staff are obliged to accept what she chooses to do and are not in a position to question her learning process (04-M26.32/04-M30.22). Marijke's perceived safety appears to be the basis for her having a successful placement (04-M28.36).

Marijke sees the communication and relationship with her mentor, the educator and ward management as providing her with stability and safety on the ward. Having achieved this foundation on the ward, Marijke feels she can operationalize her learning process outside the capriciousness of the ward staff. The continuing reports of incidental mentors she works with will provide some background information for her allocated mentor, but the initial



discussions provide her mentor with a good overview of what she's striving to achieve (04-M28.10).

For me an interesting slant to this discussion is that Marijke – although proactive in striving for stability on the ward – has not contacted the next ward prior to commencing with her placement to organise that her mentor is linked to her on the same duties, but chooses to wait until she's started on the ward to organise this. Once on the ward she will 'try as much as possible' to have lunch with her mentor (04-M30.26) to 'build the relationship of trust' (04-M32.43).

Further into discussing this topic it is clear that Marijke is not proactive in any way to organise her mentorship prior to starting on the ward (04-M32.51). Rather, she organises it shortly after starting on the new ward and then asks all parties if they are in agreement: 'up until now, it's worked well this way' (04-M34.16). I am aware of the adaptation, integration and pattern maintenance issues Marijke seems to be using to attain her goals (figure 7:3) and I find myself suggesting positive aspects of arranging mentorship ahead of time – from her showing a serious approach to the programme to reducing her dependence and providing herself with a feeling of security. I'm aware that this is potentially a trap I can get into by turning my research interview into a supervisory session, but also by transferring my issues onto the student.

	<b>Means</b>	<b>Ends</b>
External Aspects	a. ADAPTATION Economy	b. GOAL ATTAINMENT Politics
Internal Aspects	Kinship and community d. PATTERN MAINTENANCE & TENSION MANAGEMENT	Cultural organisations c. INTEGRATION

*Figure 7.3: Social system based on Parsons (Fulcher and Scott, 2003)*

Discussing the challenges Marijke has faced in dealing with her mentors in the past seems to cause her to withdraw and play down her position and the criticism she's shared during the meetings we've had. She doesn't discuss the issues she has with individuals, even



though she had mentioned earlier that if she had a problem with someone, she would discuss it directly with them (04-M39.41).

December 2005:

Marijke is very excited at the start of this meeting and sounds very happy to tell me that she's moved into her own flat with her girlfriend (05-M01.23). She's pleased she's now out of her previous flat share as she wasn't too happy with her flatmates there (05-M02.36).

Marijke tells that she had a substantial delay in her studies at the end of the last academic year due to her knee operation (05-M02.58). Adding to the stress was a fatal accident at the end of April in which, from a distance of two metres, she witnessed a woman cyclist being knocked down by a lorry as she was cycling to collect her children from school (05-M03.13) – this experience added huge pressure to the stress she was already experiencing. Marijke contacted the nurse affiliated with the team that specialises in supporting staff who have been exposed to traumatic experiences for short-term counselling (05-M04.07).

After witnessing the accident Marijke identifies that she had a physical reaction to the situation, but doesn't feel that it's changed her view of life in general – rather, it has confronted her with the facts (of life) – she has had moments when she feels that she should 'do what she wants to' and live life but the flip side of this is that she wants to complete the programme (05-M36.58). Marijke is aware that she is better able to deal with the trauma of the situation when she's at work, but can be quite overwhelmed by it when at home (05-M40.22): 'you expect it in a hospital, but not that someone is killed in front of you when you are walking down the street'. She has tried to deal with the situation on her own, but finds it unpleasant when people ask in passing how she is – 'I don't feel like really giving an answer' – but is also aware that she feels better when she has spoken about it.

Perhaps it has something to do with the accident, but Marijke feels that the deaths of patients on Ward C made a deep impression on her. Perhaps there's a subconscious trigger resulting in an increased feeling of stress and palpitations (05-M41.59). Marijke tells that she's not a church-goer ... that it may be easier if you can explain things as being God's will. She feels that you create your own coincidence and need to deal with situations as they arise in a positive way. Witnessing the accident with a friend has resulted in their



talking of it often and long and has resulted in their developing a different relationship to the one that they had prior to the accident (05-M43.46): 'I don't think about *why* it happened, but rather *how* to move on ... I give myself permission to feel bad some days,' says Marijke, describing how positive and negative days alternate.

Marijke is very proud that she has managed to complete all her academic work and is now ending off her third year regardless of having to deal with her knee operation and six months' revalidation, witnessing the accident, moving house and starting a cohabitation relationship with her partner (05-M04.50).

Marijke doesn't feel that she has changed dramatically during the programme, but is more self-confident and feels she has developed her own style of nursing (05-M24.39). According to her, her approach to care is very different from that of her colleagues on Ward B, where the registered staff strive to have all patients 'done by 10 am' (05-M25.33) – by 'daring' to stick to her own nursing norms, Marijke feels that she has grown in stature as a nurse. The 'older' nurses (nurses who've been on the ward for a long time) don't really appreciate Marijke's approach but, here too, Marijke sees how she's developed. Her communication is more direct and she enters into discussion a lot more quickly. It's interesting to hear how Marijke is able to underpin her decisions with arguments and, although she listens to the rationale of her colleagues, she doesn't alter her actions unless she feels that her colleagues are able to convince her with their arguments (05-M26.44).

Looking back on the time since returning from her knee operation, Marijke talks about her learning process and how the educator 'sat on my skin' wanting her to make her learning goals concrete and measurable. Marijke tells how difficult she found understanding this approach, but that the supervision at school helped her to develop an insight. During the placement on Ward C she feels she took her reflections to a deeper level than at the present time on Ward B. This deeper reflective level Marijke speaks about, is one of professional growth and development and provides her with a sense of peace (05-M34.07).

Marijke hasn't started to think about how she can prepare for the last, lengthy placement of the programme – she rather wants to concentrate on ending off this current placement on Ward J (05-M47.30) – but thinks that the positive



end she had to the previous placement (Ward C) (05-M49.30) will stand her in good stead on the next ward.

In comparison to Marijke's experience on the previous ward, she has grown in self-confidence due to the fact that – against all odds – she achieved her academic objectives. In addition, during the six-month period of post-operative recuperation she underwent large personal growth through reflection, and the discipline she needed for her rehabilitation she has been able to transfer to her studies (05-M31.30).

Marijke reiterates what she said during our previous discussion relating to her self-confidence increasing due to arranging her mentorship. This is how she commenced her current placement on Ward J and she feels that the discussions with the mentor and educator give her 'permission' to be herself (05-M07.45). In addition, her placement on the previous ward (Ward C) commenced when she was still in post-operative recuperation and worked as the ward secretary for the first two months of her placement. This meant that she already had a position on the ward prior to taking up her student nurse status (05-M08.45). Prior to starting her placement on Ward B Marijke had heard many negative stories about the ward and its organisation which resulted in her setting a strategy for herself – she intended first to learn the basic principles of the ward routine and then extend her boundaries ... she was first going to suss things out (05-M09.24/05-M30.15).

In previous meetings we've spoken a lot about the perception that Marijke is not serious enough in her attitude to her studies. Marijke responds that she has the confidence of the team of Ward B due to the way she has shown that she has an overview of the ward and control of situations as they occur. Now that she has the team's confidence she gets more space to develop her own way of working. As far as Marijke is concerned the team's confidence and trust in her is a result of her strategy of adapting to the ward culture – first learning and demonstrating the basic routine and only then extending her boundaries to develop an individual style of nursing based on her personal philosophy of care (05-M28.28).

Although things are going well, she knows that the team on Ward B is 'not my team'. 'I'll reach the goals I need to ... and I'm busy with that' (05-M10.06). Marijke tells that she wants to be a 'team player' with a social element outside of work, but that the team isn't like that on this ward: 'it's a group of



individuals' (05-M11.00). 'The team is shallow and so I stay shallow myself' (05-M11.37). 'Not the team, the (individual) members nor the specialisation appeal to me' (05-M12.04). Marijke is not prepared to play a role and is biding her time until January, when she moves to the next ward (05-M12.13). Marijke is aware that her attitude has an element of self-preservation as she hasn't clicked with the team on Ward B (05-M13.00).

I find this situation to be quite unacceptable and feel frustrated that I'm not able to take action to change the dynamics on the ward. Hughes (2001) discusses a process of depersonalisation among hospital staff, resulting in demoralisation and frustration. The way in which I'm seeing Marijke 'tread water' until the end of her placement makes me angry – I feel the same sensation as I did as a student when I had the confrontation with the staff nurse during my first night duty ... I want to grit my teeth and obtain justice for 'my' student. I become very aware that bullying gives rise to bullying and feel ashamed at the insight I've gained but, at the same time, feel frustrated as I would find it very difficult to deal with it in any other way than to 'stand square and show brawn'. I think back to Linda's show of 'power' with the student nurse (page 114) – my shock at her confession did not, I think, have so much to do with her attitude, but rather my recognising that that is how I respond in situations when I feel elevated 'above' the other. I find this confusing as the students I work with, largely, give me feedback that I'm approachable and don't seem to perceive a status difference ... could this elevated stance only come into play when I feel that an injustice is being done? As now, in Marijke's case ...

Marijke is now on Ward B, but is becoming increasingly aware that she doesn't really cope well with fixed routines in patient care: 'It doesn't fit with me, I need more freedom' (05-M05.45). She is contemplating choosing a different study route in the direction of sociology or psychiatry, but will miss (working in) the general hospital if she were to leave (05-M6.03). She is looking forward to her choice of final placement on Ward K, where she'll be able to provide somatic, but also extensive psychosocial, care (05-M06.40).

Marijke feels that her 'best' wards have been specialised, non-surgical wards that admit a wide range of patients (05-M13.27). Wards using clinical pathways she finds restrictive: 'I give patient care in my own way and it isn't task related; with clinical pathways you have to use the standard every day, every step – it's a checklist' (05-M15.03). 'There are a few small things you can do within the clinical pathway', so Marijke tries to give personal attention



to patients when she picks up on the individual's hobbies and personal history. She finds this approach important as it is an intervention for boredom and provides a social contact that forges communication between patients and stimulates interaction on the ward. Marijke finds it important to create a personal atmosphere on the ward and she's aware that she feels comfortable in this type of open environment (05-M16.31). Marijke is also convinced that by communicating with patients about their interests and life experiences and by showing personal interest, she develops a relationship of trust. There are, after all, 'many unexpected things in a hospital and patients quickly lose their autonomy. So an increase in contact means an increase in (the patient's perception of) safety' (05-M19.00). She's had feedback from colleagues that there's a happy atmosphere in the rooms that are allocated to her and that her patients 'look happy' (05-M20.58). Marijke seems to think that, at times, there appears to be a tension between the patients and the nurses (05-M21.26).

Marijke's objectives in having personal contact with patients is to promote safety, build trust, and develop a relationship of negotiation and equality between nurse and patient in which the patient is more in control: 'It's really important to negotiate – the patient has lost all control over his life and (by having more control) feels more human' ... Marijke is quick to underpin her philosophy with her own experience as an immobilised patient (05-M22.26).

It took Marijke some time to feel comfortable on the ward and to realise how she wanted to nurse. Supervision in the school setting, as a method, was a valuable instrument in a process that promoted positive action within the cohort. Marijke sees the staff on Ward K as examples of nurses who 'are themselves' (05-M50.50).

June 2006:

In the course of our discussion Marijke tells of her search to find herself during the course of the programme.

At the start Marijke searched to find out what sort of person and nurse she was and identifies many factors both in the hospital environment and outside that were working synchronously towards her personal development (06-M15.21). This is the first placement where Marijke is quite happy that she can be 'herself on the ward; she feels comfortable to joke and have "fun moods" ... and I think the patients can also appreciate it' (03-M699-701). She feels



that the ward atmosphere is 'like that already – open and friendly'. This makes her joke more quickly, as she is otherwise quite reserved '... certainly in the beginning' (03-M708-711).

She goes on to say that her development is inextricably linked to her feelings and intuition (06-M05.42). 'I've learned a lot about myself – I react to situations, but now I know that about myself' (06-M14.35). This self-observation is also apparent during a previous meeting in which Marijke feels that she has 'become quite a bit more serious' (04-M52/04-M125) and is more aware of how she comes across to other people (04-M59).

The permanence of her relationship with her girlfriend didn't really have a lot to do with it, although she admits to needing the security and stability of a home situation. 'I come across as being self-confident, but I need a lot of assurance. It runs parallel to how I feel now that I have the security that I've passed all the tests and assignments and have the security at home – it's all going well' (06-M06.14).

On the subject of her sexuality, Marijke is aware she needs to gauge the atmosphere of the group before coming out. It (sexuality) is not the most important factor, but she finds it important that people accept her as she is (06-M07.35).

A substantial number of the male nurses on her current ward (Ward K) are gay and Marijke admits to having come out a lot more quickly on this ward (in comparison to Ward B, where she came out only when she and her partner moved in together). The atmosphere on this ward is more open in all aspects, also regarding an individual's level of knowledge. The culture on the ward calls for strong skills and Marijke tells that she is valued for her ability to communicate and interact (06-M08.28).

The culture on this ward is, according to Marijke, open in other aspects too. On a number of separate occasions she was given spontaneous compliments by registered colleagues, which caused her to 'grow a metre'. However, the flipside of this was the realisation that this was the first time in almost four years of the programme that she'd been given compliments, without specifically asking for feedback. Marijke is shocked at this realisation '... but when you do something wrong you're slaughtered. Actually it's bad.' (06-M09.18)



Looking back on her journey, Marijke feels that she's accumulated knowledge through experience and age: '... I've become more complete, more self-confident.' This was apparent during her placement on Ward B where she had the confidence to realise that she was in her final year and that they could 'take a jump ... I know where my insecurities are and what my strengths are' (06-M10.47).

To prepare herself for the Ward B placement Marijke focused on having a single goal ... passing the placement, regardless of what she'd heard ahead of time about the ward: 'I've grown and I show myself within the context of the ward culture' (06-M11.54).

The negative experience Marijke had as a level-4 student – instead of it remaining a negative influence, it has resulted in a subconscious drive to show that she is capable of succeeding: 'Stubborn,' says Marijke with a grin (06-M25.55). While on the subject of being stubborn, Marijke tells how, after witnessing a fatal accident, she was having counselling sessions to help her cope with the trauma from a member of the team specialised in supporting staff who have been exposed to traumatic experiences. During one of these sessions her counsellor suggested that she redo a year of the programme as she was running behind schedule with her academic work and still had all the tests and assignments to complete. In the same meeting the counsellor suggested that Marijke was perhaps not able to deal with stress adequately. 'Well. It's exactly when people say that I can't do something that I decide to have a try at least.' (06-M28.03) 'And it all went well, with 7s and 8s<sup>6</sup> ... that helped a lot. It gave such a kick to my self-confidence when I went to Ward B. If I was successful with all that (the academic work), I can conquer the world.' (06-M28.57).

I'm curious about what motivates Marijke to want to nurse. She tells me it's something she's always wanted to do and has always known that she could channel her passion into nursing and caring for others: 'It's a profession that fits with me and gives me the chance to develop.' Nursing is generic and so it provides an opportunity to try different things ... But I'm also stubborn. ... I think it's a calling for me, not in a religious way. It fits with what I want to do – work with people using your hands and your head. It fits with me' (06-M23.00). 'I want to help people in the best way that I can ... now, this is my

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<sup>6</sup> Maximum mark equals 10.



best way ... to help people ... it's in my character' (06-M25.25). Marijke refers again to nursing being a calling: 'The red thread through my journey is clearer, more focused ... aid to a developing country ...' (06-M35.12) '... my life is good and I want everyone to have a good life ... a sort of giving thanks ... it's egoistic if you turn your head and don't look (at other people's suffering) ... a form of solidarity. I give more than I take ... I don't need that much to be happy ... I give, that's what makes me happy' (06-M36.01).

Ward B was a challenge for Marijke with respect to learning objectives – these were focused on concrete products such as mentorship, time management and the like, but they allowed her to focus. Now, on Ward K, setting objectives is easier, although her feeling of being in a 'Valhalla' brings different challenges because she feels so at ease in the group. The challenge is now to remain focused on having the report of her final assignment on the follow-up care for patients with an alcohol dependency completed in time. Marijke recognises this as being a potential trap but, at the same time, acknowledges how she's grown and is now able to recognise the risks and be proactive (06-M29.42).

Again I feel satisfied with my interaction with my participants and Marijke says: 'I've enjoyed our talks – they're good evaluations for me ... when I think of how I spoke about things in the beginning I see how much self-awareness I've developed' (06-M36.09).



## **SECTION EIGHT**

### **Isa's bicycle ride**



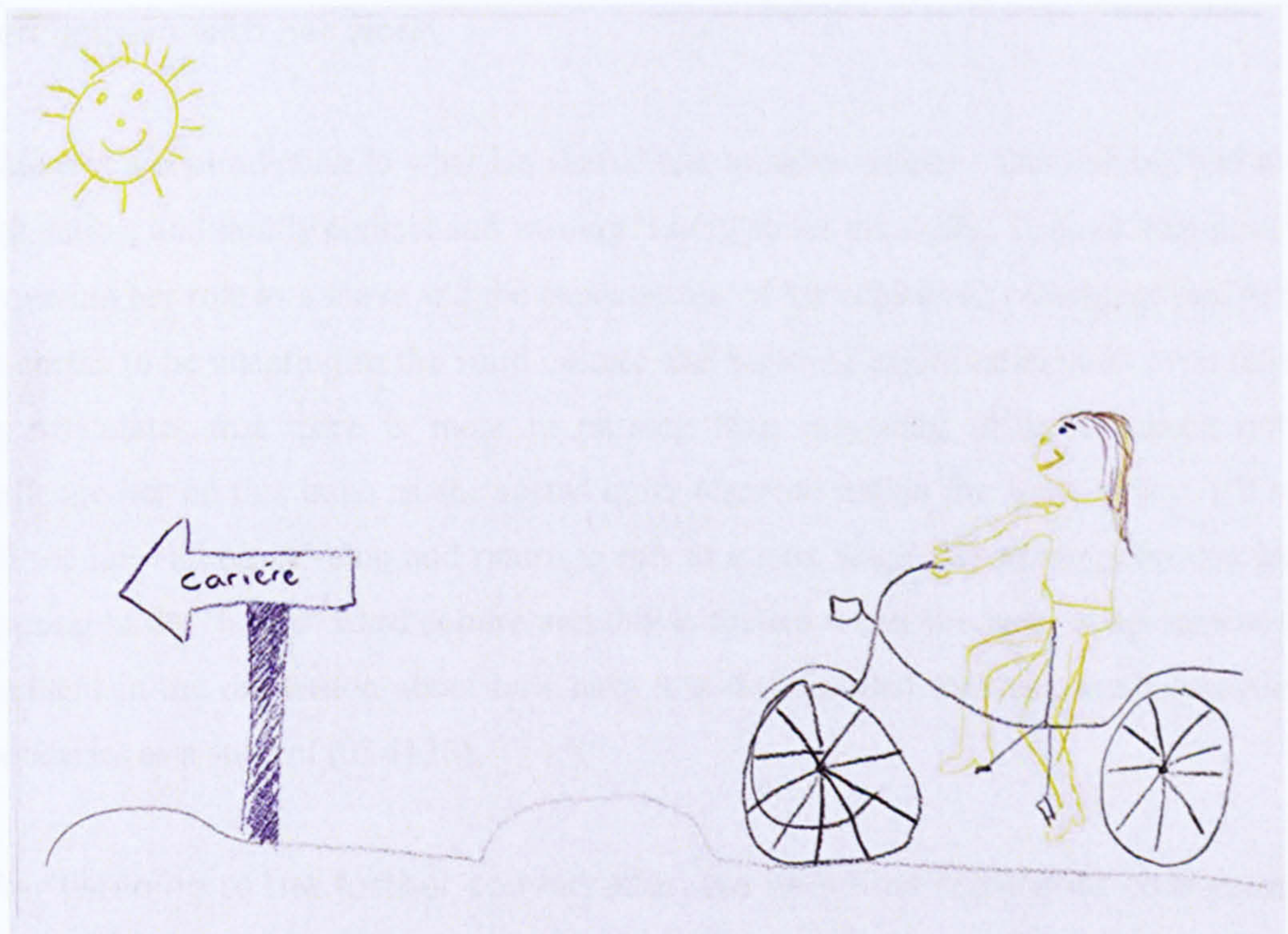
### Isa's bicycle ride

June 2006:

Isa's bicycle path: 'black, brown, blue, yellow ... no specific reason, they're just my colours' (06-I35.30).

'That's me on the bike – a real Amsterdam black bike' (06-I00.22) '... behind the last hill the sun is shining ... hopefully a good career with sunshine ... I look to the future with confidence' (06-I01.10).

'I'm yellow (in the drawing) – it's a happy colour ... but not one (a colour) that I consciously chose ... the bike is black ... I have a black bike ... the career (signpost) is blue ... a lovely, clear colour ... optimistic' (06-I01.29).



*Isa's bicycle ride*

December 2003:

The first focus interview and Isa seems quite hesitant to come forward with her experiences – perhaps this has to do with the two fellow-students in the group who are older and very articulate. The two students tell how they've wrestled with mentors and been, at times, overloaded with too many patients – Isa nods and mutters agreement (03-I19/03-I136/03-I188), but says little of issues she's had – she seems to be an observer rather than an active participant.



Isa identifies with what her group members say about the often task-oriented approach of the surgical wards but is of the opinion that: 'It's more about the patient and their family and things ... and not really about the skills' (03-I47).

In the initial months of the placement Isa has become more confident and feels able to take on a bigger workload. The moment of realisation was when she had been working in a room with a colleague and found that she had finished what she needed to do ahead of her colleague. This seemed to be a moment of realisation for her that she could 'do more' (03-I81). She elaborates on the type of extra work she takes on: '... wound care I do under supervision of someone ... I already know how irrigation systems work ... ADL<sup>7</sup> I can manage too ... then you're quite on your way on a surgical ward' (03-I93). Isa indicates ahead of time to her mentor what she can and can't do and then gets on with her work.

I find this a contradiction to what Isa shared just minutes before – that nursing had to do with patient and family contact and was not 'really about the skills'. I'm not sure how she is viewing her role as a nurse and the expectations of her registered colleagues but, to me, Isa seems to be adapting to the ward culture and building expertise in tasks even though she articulates that there is more to nursing than executing skills. I choose not to challenge her on this issue as she seems quite reserved within the focus group. I'll wait and see how things develop and return to this at a later stage. My assumption that Isa is adapting to the 'hectic' ward culture and this is fuelled when she nods in agreement to a comment in the discussion about how easy it is to be pulled over personal/professional boundaries as a student (03-I136).

After listening to the further conversation Isa tells how registered colleagues tend to ask her to do 'more and more', without stopping to think 'she's not allowed to do that'. She needs to be constantly on her guard even though her experiences haven't been as extreme as the ones she's just been listening to: '... but you notice with small things that you must really guard your boundaries' (03-I158-164).

My waiting and listening is paying off – Isa feels guilty if she refuses to do what she's been asked (03-I168/03-I172) because she sees that the registered staff members are busy and feels bad about having to ask questions and seek advice. Although there's a feeling of

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<sup>7</sup> Activities of Daily Living



guilt, Isa's awareness of her responsibility doesn't prevent her from asking for the assurance she needs (03-I178/03-I188).

It becomes clear from the discussion that the other two members of the focus group have been in situations where some registered nurses have made belittling comments about the questions they've needed to ask – although Isa hasn't added to the dialogue, she voices her agreement by nodding and making sounds of agreement (03-I240).

After listening a while longer Isa says that she's not been met by extreme reactions from colleagues that humiliate her ... 'Perhaps they do have it but maybe they don't show it that quickly.' She adds: 'I have that idea – they have always got time for me' (03-I289).

I'm finding it interesting to observe how Isa is, to all intents and purposes, agreeing with all that is being said regarding the quality of mentorship on the wards and the apparent power issues that are played out at ward level, but later telling of how she's not experienced the situations personally.

She explains that she has two mentors on the ward, but that she doesn't often work with either of them '... it's difficult because they don't really see a line of improvement or see how I work in general'. She is, however, able to approach them if there's a problem. Isa tells how her mentors obtain their information from colleagues during student report meetings,<sup>8</sup> evaluation meetings<sup>9</sup> and evaluations at the end of each shift. Isa explains that she asks her mentors to write a short report on how they found the shift and include any feedback they may feel is appropriate (03-I332/03-I336/03-I342/03-I351/03-I357).

I am even more intrigued at – what appears to me to be – the contradiction in Isa's story. It seems to me to be an inefficient method of mentorship if (subjective) information is obtained second-hand regardless of the ward allocating two named mentors. I decide not to pursue my thoughts during this meeting as I feel Isa may become more specific in her thoughts during future meetings when we're on our own. Perhaps, I figure, she may be a bit reserved due to the group nature of the interview.

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<sup>8</sup> Report meetings are weekly meetings during which the registered staff members discuss each student's progress. The student is not present during this meeting. Ideally reports are made and fed back to the student after the meeting by the named mentor.

<sup>9</sup> Evaluation meetings take place (ideally) every 4–6 weeks between the student, the named mentor and the practice educator.



The group discussion moves in a different direction – mentorship styles. Again Isa doesn't articulate much but seems to agree whole-heartedly with what someone else in the group says. Apparently mentors come in two forms: one who just lets the student get on with their work – the implicit expectation being that the student will approach them if they have questions or need advice (03-I370) (*no space here – I think – because what the student doesn't know they also don't see*); or, at the other end of the spectrum, the mentor who discusses each patient with the student and wants to know how the student expects to set priorities and where they think they'll need help and why (03-I374) (according to the students, this form of mentorship seems to revolve around answering 'why' questions). The second species of mentor is the one the group agrees provides the best learning experience and allows the most insight and overview of the situation (03-I378/03-I385).

Daily life is not, it would seem, made up of attentive mentors asking the right questions. The students tell how they have a full complement of patients and are not able to ask the depth of questions they feel are appropriate – Isa agrees with what someone else says about getting 'sucked into the ward routine': '... yes, ... very quickly you go with them ...' (03-I460). The 'ideal' form of mentorship is discussed during the evaluation meetings between the student, mentor and practice educator and '... you come to an agreement very nicely, but it's difficult to really do it and continue with it' (03-I474). 'The first few times it works and you think, "fine". You really get tired from saying it over and over again ... "no, I'm only a second year" ... (Isa's voice gets very small) ... "take that into account" ' (03-I479).

I feel my chest constrict – the students really need to be resilient to get through the programme without frazzling. I feel there is a minimum of support for 'my' focus group members and I feel quite frustrated and a bit ashamed that they are being exploited, but also have a vast amount of responsibility – the patient, their learning process, extending boundaries and developing expertise, fighting for mentorship support and, at the same time, being vigilant that their mentors don't coerce them into a position beyond their competencies.

None of the students seems to feel that they are able to provide the sort of care they aspired to at the beginning of the programme when we spoke about it on the first day. Isa narrates how she is continually busy with routine and, sometimes, mundane tasks to the degree that she actually doesn't ask the patient 'Well, how are you actually?' (03-I554) '... and then you hope that the evening shift is quiet so that you can say something kind'



(03-I561). Isa feels guilty about the lack of attention she gives the patients: ‘... with bed bathing and things I give people attention too, but that is, of course, a good moment to give them attention, but well ... if I were in hospital ... you were only seen to in the morning and then no one saw you the whole day except when you come to do something ... that’s not really ... I don’t think it would make me feel unhappy but ... well ...’ (03-I563/03-I604).

Isa tells more about her feelings of guilt and how she deals with the situation. Although she feels guilty at not having provided the patients with the care she feels they need, it is important that she enjoys her time off in the evenings. But she also uses this time to reflect on what she could perhaps do differently in her next duty to give herself more time to spend with the patient (03-I605). She suggests having a 15-minute coffee break instead of 30 minutes: ‘... that’s how I deal with it ... I give my best too, but there comes a stage that you can’t anymore ... but I’m aware of that’ (03-I608).

The discussion is affecting me quite strongly. I’m very proud at the intrinsic motivation to care these students show, yet I’m also shocked that the students within the first three months of their first ‘proper’ placement are sacrificing their personal time and space to provide that ‘extra little bit of care’ for the patient. One thing these nurses agree on is that their lack of attention to the ‘small things’ has a direct link to their inability to plan properly and the discussion ties up with them agreeing that planning and priority are aspects they need to learn if they’re to provide the care they aspire to (03-I606/03-I650). I think that this may be the essential element of socialisation we’re dealing with as nurses – guilt-related asceticism and what the authorities (government and hospital) cash in on – no self-respecting nurse will allow their patients to suffer neglect and yet they are so neglected themselves by the powers that be. Is this perhaps the origin of the double prong in nursing – those nurses who remain caring to their own detriment and self-annihilation and the others who become uncaring in their behaviour in order to protect themselves?

June 2004:

When I meet Isa this time, she is involved in her mental health placement in an external organisation – a permanent residential group for clients with chronic mental illness.

Isa has become more assertive towards her mentors in the past six months. Initially she tried to remain invisible, but this resulted in her letting too much



responsibility wash over her (04-6-I00.40). Realisation that the mentorship style needed to change was gradual and Isa found that she was becoming more uncertain due to the fact that she felt she needed to adhere to her colleagues' requests for assistance even if it was inopportune timing on their part. This pattern continued for a little while until Isa realised that if she didn't address the issue and speak about it, the situation would remain unchanged (04-I01.43/04-I12.47).

Assertiveness has another dimension for Isa. Although she appreciates that her registered colleagues are busy with patient care and mentoring students, Isa is also very clear that some colleagues vent their feelings and frustrations at others – including the students – which is a role Isa is not prepared to play: 'I don't want to be saddled with the problems of another' (04-I12.54).

This change in assertiveness came about on the new ward – Ward C – after she'd started there (04-I02.31). Apprehensive at first, Isa soon found that her colleagues were open to discussion and feedback and that the mentorship, generally, was going well (04-I02.03). She learned to be more assertive 'one step at a time', but is acutely aware that she needs to maintain her boundaries: 'You come here to learn and you are drawn so quickly into the ward's busyness. I must always think that I'm here to learn and not only to work' (04-I15.06).

It almost feels to me as though Isa is thinking aloud as she tries to focus on her role as a student.

'It's sometimes difficult refusing to do things – people can fall out with you ... (softly) but you must first set your own boundaries before you help others ... otherwise you'll pass yourself<sup>10</sup> and go under' (04-I15.37). 'The patient will (ultimately) profit more if I learn from the situation rather than only doing tasks' (04-I16.42).

Isa finds it difficult to discuss her feelings of being exploited by her registered colleagues so: 'I just say that I don't have time if colleagues always ask for help ... I refuse even if they get angry or irritated' (04-I17.58). We laugh together as Isa explains how she makes a mental 'black list' of colleagues who structurally ask for help and those she systematically refuses to help because

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<sup>10</sup> 'Jezelf voorbij lopen' means literally 'to walk past yourself' – that you'll get out of your depth and become alienated from yourself.



she's 'too busy'. Then Isa becomes serious: 'I refuse even if the patient runs the risk of being short-changed – it's their responsibility ... if they can't be motivated, they need to find another job.' (04-I18.03).

Isa doesn't think that it's a motivation issue among her colleagues on Ward C, but rather part of the ward culture: 'You work hard and it's busy ... the mentality ... it's not always nice the way they treat each other' (04-I20.20).

Isa is pointedly not negative about 'bad mentorship', but sees it more as part of a bigger picture. The registered staff's primary responsibility is patient care and then they also have student mentorship: '... it's because they have too many tasks' (04-I03.20/04-I10.08). Realising the mentor's pressure of work, Isa feels obligated by having to ask the registered staff questions and advice when she sees they are 'so busy' (04-I02.47).

I am curious about Isa's view of her mentors if she compares the two wards – D and C. She is clear that they are two very different wards with very different tempos (04-I03.38) and while on the surgical ward she would work directly together with a mentor, on the non-surgical ward she works far more independently. Isa discusses whether she's a surgical or medical nurse in terms of stereotype – laughing, she tells that now when she's on a medical ward she's apprehensive about the next surgical placement, but when on surgery, apprehensive about medicine. (04-I20.40)

I become more curious as Isa had told during the previous interview that she worked independently (whereas now she maintains that she'd worked directly with her mentor) and was now going on to say how much she'd enjoyed the independent working she had on Ward D. Just as I draw breath to ask about this, for me, conflicting perception of the same situation at different times, Isa adds: '... it was easier to ask your questions on Ward D than it is on Ward C' (04-I04.31). 'It lies with the team and the willingness to help ... on Ward C you don't see each other' (04-I05.13).

Isa is very clear to explain that the physical and emotional difference between the wards is marked. Work on Ward C in general, and more specifically on the acute-unit, is physically and emotionally taxing – all the patients need to be assisted with all aspects of ADL, are usually very ill, stay on the ward for a long time and often need to be cared for by two nurses; and far more patients die on this ward than on Ward D (04-I05.58/04-I11.29). Ward D, in contrast, has patients who are more independent and there is, therefore, less opportunity to give extra attention. The patients are often younger and have



their own friends and so don't, according to Isa, really need a 'constant stream of empathy' (04-I11.58).

Although the emotionality of the ward is more intense, Isa feels she's well supported – registered staff ask how things are going. One quiet Saturday morning, she was able to stay with a patient as they died and was able to witness the process from beginning to end: 'it was very beautiful.' Colleagues were again very supportive by staying emotionally in touch with Isa and explaining all the phases of the dying process (04-I06.10/04-I08.11).

Isa tells how surprised she is by her reaction of finding death 'very beautiful' and the contrast with non-nurses' fear and anxiety towards death and dying. The difference between the perspectives amazes Isa: how quickly she's learned to accept death and dying as being 'normal' now that she's working with it (04-I06.58). Isa is all the more amazed by her progress as she'd never really thought about death or dying prior to entering nursing but, adds Isa, it is dependent to some degree on who the patient is: 'I have fewer problems with the elderly because it's more expected and somehow ... natural' (04-I07.22).

Experiencing death for the first time at close quarters was not a sad experience for Isa, but she tells how grateful she was for the extra attention from the registered staff – the benefit of the support was not specifically related to any anxieties she may have had, but more that she appreciated that the registered staff realised that she could have a problem with the situation (04-I08.47).

We move on to speak about professional behaviour and how a mentor can be a role model in providing psychosocial and emotional care.

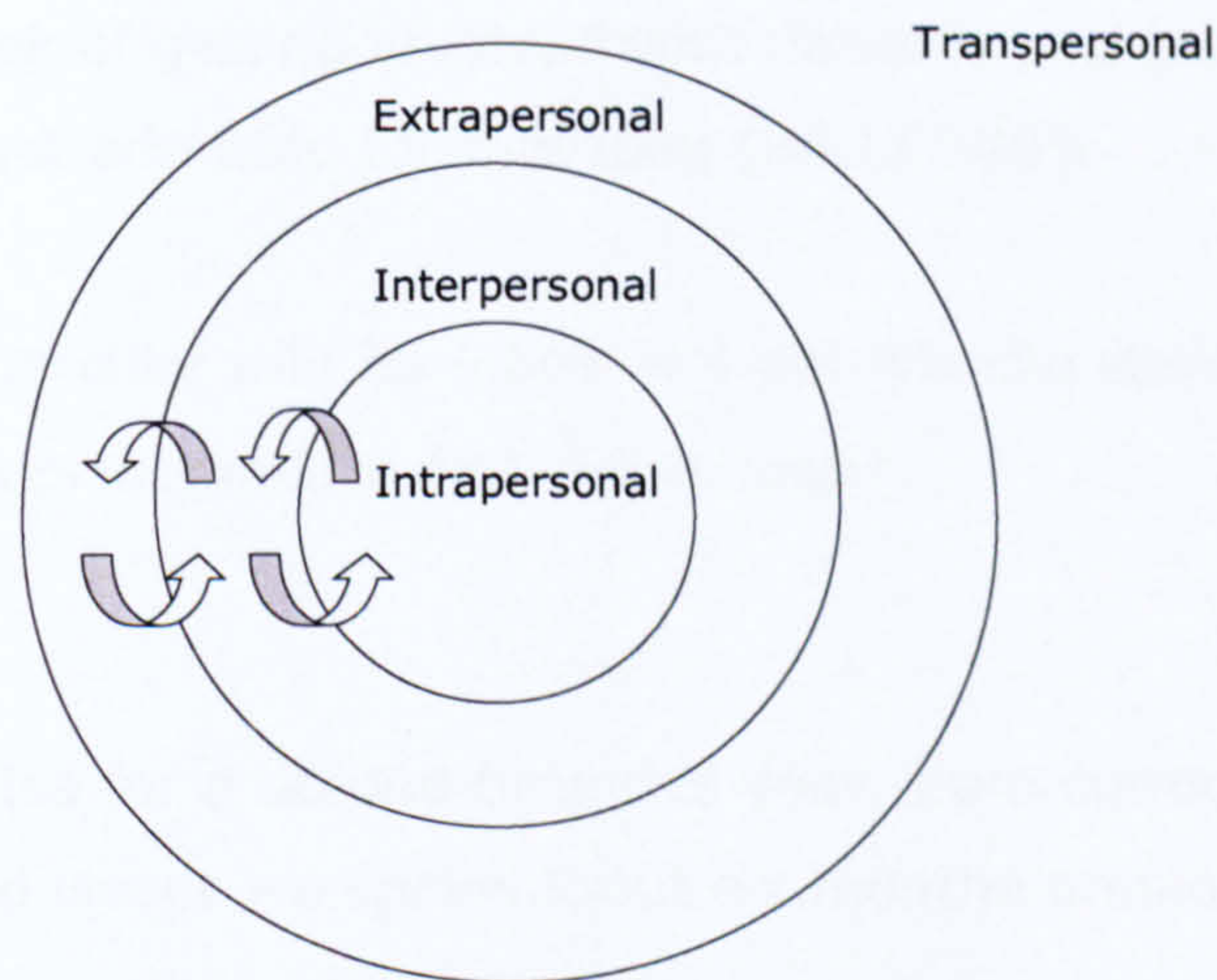
Isa refers to her current placement in mental health: 'I see that people like and value personal attention ... I try to have a more normal relationship with them' (04-I24.18). 'But I don't think the space is always there in a general hospital to give the patient attention' (04-I27.31).

Isa is obviously very convinced of the support she needs to give to patients and refers to the first workshop we did prior to starting the programme in which we discussed her vision of care. At the time she'd chosen a photograph of a woman supporting a little boy to ride a two-wheeled bicycle. The symbolism of the photograph has not changed for Isa: she stills sees the nursing role as being one of support: 'it depends per person on how



long you walk next to the bicycle to support them' (04-I27.55). Isa appears to have mastered an interaction between the Intrapersonal, Interpersonal and Extrapersonal domains in terms of the DeMeulle & D'Emidio-Caston (2003) model (figure 8.1). Her personal beliefs, values and thoughts interface with group dynamics and interpersonal communication, while taking organisational dynamics, ward politics, professional standards and stakeholders (most importantly being the patient) into account.

I find it interesting when Isa tells that she's not more aware of situations due to our previous interaction, but thinks about situations only as they arise. Occasionally she thinks of my research, but it's not something that is uppermost in her mind (04-I23.00). This is a marked difference to the feedback I'd been given by the previous three participants.



*Figure 8.1 Isa's learning process (June 2004) illustrated in terms of the DeMeulle & D'Emidio-Caston (2003) model*

Isa has shared a lot with me during our meeting and, considering how she'd referred to her need to learn from situations, I'm curious how she intends planning her learning process for the next year. So I ask her about her choice of objectives.

Isa names a list of objectives for the future – she seems well prepared for this question. These revolve around her boundaries, learning how to clearly indicate knowledge and skills she doesn't know/have or isn't sure about and creating space in which to be able to learn: 'I'm more aware that I need to learn so much ... I'd almost like to restart the second year,' she says, laughing, 'I'll NEVER learn it all. (04-I28.50). 'I want to discuss my boundaries as my expectation (of the placement) ... and then stick to them,' says Isa softly (04-I30.11).



Isa explains that so many small things happen that have to do with boundaries, but that it is always afterwards that she thinks the situation could have perhaps been different. 'I doubt and then I notice that I don't feel good (about a situation) ... I feel uncomfortable ... but I do speak about it' (04-I31.22). Isa resolves to give colleagues one-on-one feedback if/when she doesn't feel comfortable with situations (04-I32.50).

Following a situation during her mental health placement, Isa is aware of her personal and professional boundaries in dealing with patients. There was an element of role confusion which resulted from an imbalance between professional involvement and distance: 'It (the role confusion) is a risk that someone can be hurt ... but you must be open otherwise you don't get anywhere' (04-I37.30). In the discussion Isa explains that she doesn't think there's too great a risk of getting involved with patients in a general hospital as they're normally not admitted for that long (04-I37.40).

I feel humbled by this meeting with Isa – how is it possible that students actually ever graduate with all the issues they need to deal with en route?

December 2004:

I decide to speak to Isa for a second time this year. I am curious to know how she's dealing with the issues we spoke about six months previously.

The first thing that Isa shares with me is that she's more independent and feels surer in her work (04-I00.54): 'I am aware of the complexity of the patient ... that's what I think about' (04-I01.20).

Isa tells that she has developed a broader view of her work, which provides her with stimulation for the programme. At the end of the second year Isa had a dip in her enthusiasm. Things are better now – she's enthusiastic when she gets home at the end of a shift and is eager to carry on (04-I02.27). I want to know what Isa means by 'a broader view'. This is, according to Isa, largely clinical: 'there are more things that I notice, planning is better, you know more, I can think of more things and recognise things more quickly, I can do more things myself' (04-I03.11).

This broader view may have something to do with the fact that Isa is in a placement on Ward E. She tells how she has switched completely to surgery



(after indicating during our previous meeting that she found it difficult to choose between medical and surgical nursing, but still finds it a difficult choice to make for her final differentiation). Surgical nursing seems to provide a degree of clarity for Isa – as a specialisation it's clearly demarcated. It's easier to maintain an overview and (it) is more bound by protocols. Medical nursing, in contrast, is less defined and more diverse (04-I03.54).

Isa's difficulty in choosing between surgical and medical nursing is due to the fact that she feels that she needs to work for a longer period on the ward, whereas as a student she's allocated for a period of six months: 'I feel I must make a good decision ... on a surgical ward it's very linked to protocols ... I think I would find it boring and monotonous quite soon' (04-I05.35). 'The diagnosis is clear and the focus is on treatment ... It's interesting on medical (wards) because there's more to think about ... the patient is, naturally, central but there's more of a search to find the diagnosis' (04-I08.06). 'The nursing care is different – there's more psychological support when it's (the diagnosis) unclear ... surgical patients are relatively healthy ... medical is more complex' (04-I09.04).

Isa's independence on medical and surgical wards is something she's spoken about since our initial focus interview. She has the idea that her independence is as a result of feeding her work back and discussing her patient care with her mentors to provide them with optimal feedback about what she's doing (04-I33.25). An extra dimension is that Isa prefers to work independently and so creates situations that allow her to work as independently as the situation allows (04-I04.46).

Isa feels she's developed independence due to her undertaking nursing activities and tasks independently and reflecting on what did and didn't go well. Whereas during previous interviews Isa told how she worked independently, but needed to ask questions, and then found it difficult to 'be a nuisance' to her registered colleagues and mentors, she now finds that her strength lies more in the area of independent decision-making (04-I14.58). Since the start of the programme, Isa has developed experience and a repertoire of skills which means that she needs to ask questions/seek advice only in exceptional situations. She gives me an example of clinically assessing pain in relation to the patient's diagnosis and analgesic pharmacology within the contact of a new ward and an unfamiliar patient category (04-I16.01).



I get the feeling that Isa's questions relate to task-related patient care and ask her about this. Isa gives examples of how she discusses other aspects of care too: 'The atmosphere on a single-sex unit is different ... a group of men seem to lose decorum and show inappropriate behaviour ... I find that difficult and so I spoke to the team about that ... how do I deal with it? ...' (04-I18.20).

Isa refers to the photograph she chose during the orientation period of a woman supporting a child on a bicycle. She still feels strongly that nursing focuses on the welfare of the patient – it's important that they feel supported, comfortable and safe (04-I10.22).

An interesting part of our discussion centres on Isa's comment that her vision of care hasn't changed, even though her image of nursing has changed in the past two years of the programme. She finds nursing 'nicer' than she originally thought it would be (04-I11.20). Isa goes on to say that nursing is broader than she thought it would be and, now that she's involved in clinical decision-making, it's become more interesting. Nursing provides more depth and an opportunity to execute more technical procedures than Isa's previous occupation – that of doctor's assistant where she worked in an out-patient department of a general hospital (04-I13.20).

Isa is well able to maintain an emotional distance from her patients even though some situations can make a big impression – especially being confronted with a patient in the same age group. She is quick to add: 'But I see that colleagues have the same problem' (04-I17.21).

Isa is still wrestling with maintaining a balance between spontaneity and distance in her relationship with the patient. She tells how she has the tendency to expose too much of her personal life during spontaneous chats with patients and worries that this is not indicative of professional behaviour (04-I34.48).

'Colleagues need less help from each other on this ward.' Isa explains how, on Ward E, there's less need to help colleagues than on Ward C and that she now provides help immediately it's asked. On this ward colleagues approach one another easily, but they also evaluate throughout the day and adapt the workload accordingly if necessary (04-I19.50).



Isa finds it easier, but still difficult to refuse help to colleagues. Feedback to colleagues is more of a challenge and she doesn't feel confident enough: 'I don't dare ... find it scary ... you get people's noses out of joint' – Isa tells how she spoke about this communication difficulty during a progress evaluation and was given 'permission' by her mentor to 'confront' colleagues when necessary (04-I21.37). Still Isa is afraid that a confrontation would result in repercussions on the ward, although she doesn't think that there are 'power issues'. Feedback would influence the atmosphere on the ward: 'something would need to be done with it and people's noses will be put out' (04-I26.56). Isa is not convinced that it would influence her assessment. She is more concerned about the personal interaction: 'I'm still wet behind the ears – I've just started'. Isa adds with a laugh: 'I'm going to work on this image now ... giving feedback is going to be a point of attention' (04-I25.16).

Although giving feedback is a skill still needing courage, Isa tells how she gave a colleague feedback on Ward C and how well it went – she and her colleague were able to resolve a patient-related difference of opinion by discussing it before it escalated (04-I28.47). Even though this was a positive experience, Isa still perceives a high threshold that prevents her from giving direct feedback to registered colleagues: 'It takes a long time before I am comfortable enough to give feedback ... it's also because everyone works so much on their own and so there's not that much communication' (04-I30.24). Although Isa feels there's a definite hierarchy on the ward at ward manager and senior nurse level, she doesn't feel there's a difference between registered staff and the students (04-I31.44). Her angst at giving feedback has more to do with creating a negative atmosphere on the ward than being kept in place by power and hierarchy-related dynamics. Isa's reticence to confront is a personality trait she recognises in her personal life, so isn't anything new to her (04-I23.20/04-I27.01).

Isa talks about a shift in her personal life which allows her to see the relativity of things and appreciate the smaller things of life: 'I know how terrible it is that things can happen to you (referring to situations she's seen as a nurse)' (04-I24.13). Professionally Isa feels more of an employee than a student. She sometimes wants to obtain more detail from the medical dossier, but feels she doesn't have the time to set aside from the direct patient care she's been allocated. The only time that she feels comfortable to do this is during the weekend or on public holidays when things are quiet: 'I find it difficult to



ask for space because I'll make it busier for my colleagues ... I feel guilty and find it difficult' (04-I36.33).

I'm interested that Isa finds it important to have depth of knowledge as it promotes the quality of care and increases independence as a result of a greater understanding of the patient situation, but she still sees it as something 'extra' and separate from her role as a nurse. According to Isa, no one has ever commented on her reading dossiers or collecting extra information related to the patient (04-I38.34), but still she feels that she needs to get permission from the ward management and all of her colleagues. Any extra learning activities need to be approved for 100 per cent by all staff before she can hand over her direct patient care (04-I38.34).

With a shy giggle she suggests that she'll take this forward as a personal learning goal (04-I40.00). But, on a more serious note, Isa's most important learning has been in developing her clinical perception of the patient and her clinical rationale (04-I40.49). Again I feel a bit sad that she feels restricted by her perception of the clinical environment that expects her to develop an in-depth understanding of the patients in her care.

December 2005:

Isa has started her final placement on Ward K. She reiterates that she's been happy on all the wards; however, this ward is somewhat special. She found her niche on the ward very quickly – 'within a week' – this had mainly to do with the ward staff. Isa sounds very enthusiastic as she tells how comfortable she feels and that she hopes to be able to stay on the ward as a permanent staff member after she qualifies (05-I00.19). 'It's different on this ward, they get stuck in (and do the work) – I like that' (05-I22.42). 'There's an easy way of communication ... and the sort of people, it's a different team combination – a lot of men and there's open communication ... it's a different atmosphere' (05-I16.32).

Isa finds a good interaction between staff on the ward and the patient category and combination of diagnoses presented on the ward makes for a good mix of complexity and is, therefore, interesting and challenging (05-I00.57). 'But there's also a lot of humour around situations – it increases your pleasure at work' (05-I30.08).



The 'dilemma' of medical or surgical nursing appears to have been resolved for the moment. With a broad grin she says: 'I was happy on surgery, but I'm more a medical nurse' (05-I02.28).

Expertise and quality of care are clearly important aspects of professional practice for Isa. Initially she was uncertain whether she was seeing the bigger picture of care for her patients. To a degree this is still an issue when it comes to highly complex patients, but in most situations she feels she is able to make independent considerations and so build her certainty and self-confidence (05-I04.42). 'You discover things to try and see what fits with you' (05-I03.24).

I smile inwardly at Isa's trial-and-error approach to developing her expertise (05-I07.00) and think how interesting the contrast is within one person. She's prepared to take calculated risks to develop her skills, but doesn't 'dare' to use trial and error when it comes to communication, feedback and confrontation with colleagues.

The angst of giving feedback has fallen into place on Ward K – feeling comfortable with her colleagues has allowed Isa to make some sort of 'click' which is now allowing her to give feedback and confront issues without it being a problem (05-I15.09).

The change in Isa with regard to feedback and the relationship she now has with colleagues could indicate that this ward is less hierarchical (even though she'd said in previous interviews that power was not an issue). However, the change in Isa's behaviour could also have some relationship with the fact that she's almost completed the programme and now feels she has more authority to have an opinion.

Isa explains how professional practice at degree level has other dimensions for her. It means the balance between nurse/patient involvement and distance. It also means developing the aptitude to feel what people need and being able to meet these needs. And it means rising above direct patient care and contributing to the ward organisation and development (05-I06.00).

We speak about Isa's views on death and dying. Terminal and palliative care for the older person fits into life's expectations and the normal pattern. This is more difficult and 'it touches you more' when it comes to nursing younger patients, and especially those in your own age group, as was the case on Ward E (05-I09.11), and where young families are left behind (05-I30.47).



'When young people die on a ward it leaves a horrible atmosphere' (05-I31.30); 'I think about situations, but I don't feel sad when young people die, I just think it's terrible' (05-I32.41).

The background to the terminal illness also seems to make a difference to the degree to which Isa can relate to the dying patient and is touched by the situation. In general Isa admits to feeling more attachment to patients who have been diagnosed with illnesses such as cancer – an illness that she feels she has just as much chance of contracting. But she feels more distant from patients diagnosed with lifestyle-related, almost self-inflicted diseases that she feels are not a personal risk to her: 'I don't think it's their own fault or anything ... but I just don't feel the same attachment' (05-I09.57). 'I give people more attention if I can identify with their situation ... I'm aware of it ... but it just comes spontaneously' (05-I10.50). 'I give all my patients the basic care they need, but some I just give a bit more ... I've not yet had the experience (of getting involved) with patients who have a lifestyle-related illness on this ward ... the category of patient doesn't allow that kind of contact'<sup>11</sup> (05-I11.36).

At some level I'm taken aback by Isa's frankness. Surely this is discriminatory and contrary to professional codes of conduct? Yet I'm once again humbled by Isa's openness and human approach to providing care. It's naturally inappropriate to discriminate openly on the basis of age, sexuality, social status or lifestyle, or in fact any other individual characteristic but I'm coming swiftly to the conclusion that it's purely human to be judgemental. Perhaps this is another myth of professional socialisation – that, as nurses, we see ourselves as superhuman and attempt to negate any personal preferences we may have – this must contribute to alienation and role-conflict. Is this the essence of our dependency (overcompensation) and self-loathing which causes us, as nurses, to be subservient and not to stand up to authority?

Isa hasn't been able to ask colleagues to take on her patient care in order to create protected space to learn. She has rather budgeted with her own time and planning if she's needed to undertake extra learning activities on the ward (05-I14.10).

In some ways I find it unfortunate that Isa has not managed to negotiate study time on the ward with her colleagues, but creating a situation in which she's not dependent on others

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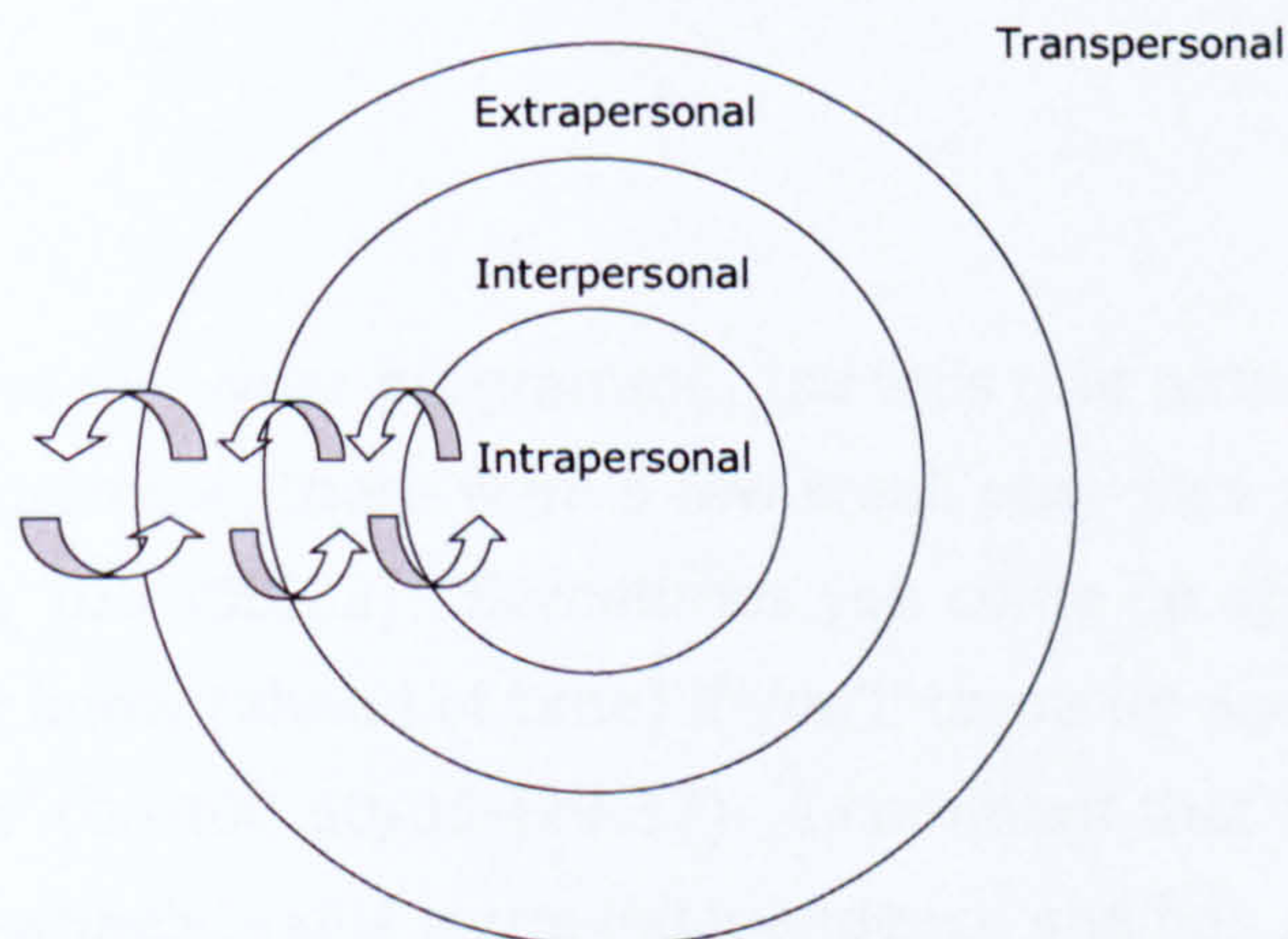
<sup>11</sup> I have replaced actual diagnoses and patient categories with generic descriptions to protect individual and ward anonymity.



will probably stand her in better stead as a registered nurse. She will have learned to incorporate preconditions into her day during which she can explore specific items in more detail – this, to my mind, is an essential part of lifelong learning.

Learning has taken place in other ways for Isa. Initially in an acute situation she remembers being slightly in panic and thinking she'd done something wrong (05-I23.37). In the past two months, however, she stays calm and cool and even manages to operate in acute situations with patients she doesn't know that well (05-I23.24). Isa explains this development in rational tones: 'It has to do with experience – I have more insight into the different components (that influence the situation)' (05-I25.38).

Isa is confident as she tells me that she is able to cope with complex patients: 'there's a certain routine, but I also always think why I'm doing what I do'. She's very aware that there is a risk that 'you can do things automatically ... I hear that from others too' (05-I26.59). But Isa feels that the best part of the nursing profession is that she always needs to remain alert and keep thinking (05-I28.17) and 'if colleagues don't do that, you go into the mist<sup>12</sup> ... it's dangerous' (05-I28.40).



*Figure 8.2 Isa's learning process (December 2005) illustrated in terms of the DeMeulle & D'Emidio-Caston (2003) model*

As a person Isa feels she has learned a lot through the programme. The confrontation with sick people has caused her to count her blessings: 'I've changed ... absolutely ... I'm older, but work has been influential – I don't complain that much and I'm grateful my family is healthy. I'm satisfied more quickly (than before) and I don't make a problem out of little things' (05-I33.38). Isa seems to have integrated learning between all the domains as suggested in DeMeulle & D'Emidio-Caston's (2003) model

<sup>12</sup> 'Ga je de mist in' literally means 'go into the mist' – you get lost and lose your way in a situation.



(figure 8.2). This integration seems to provide her with an essence of professional maturity and calmness.

Looking back, Isa has enjoyed the programme and finds it a bit of a pity that it's over ... although she's pleased to be rid of the 'endless written assignments' (05-I35.40). 'They (the assignments) were absolutely beneficial ... through writing you're halfway done (working through issues) ... you create objectivity by writing things down ... you learn more about how to deal with things the next time' (05-I36.37).

In the course of the programme the clinical education changed and bi-weekly reflective sessions in the clinical setting with the full student group were replaced by supervision sessions at school in groups of five. Isa feels that discussing work-related situations in the group (as they did at the beginning of the programme) was valuable. The clinical education is now presented in learning strands dealing with specific lesson content and is not directed specifically by the student experience – Isa feels this is 'a pity'. There is no specific opportunity anymore to discuss work-related experiences with the whole group. Although the smaller supervision group is valuable, it doesn't provide a platform to share experiences with the whole group and 'you are dependent on those in your group' (05-I37.50).

June 2006:

Looking back on the four-year programme, Isa tells that although she 'cycled through'<sup>13</sup> the programme, there were a few small obstacles and hills ... it didn't 'just happen' (06-I00.22): 'Sometimes you come up against difficult things ... you don't know (ahead of time) if you'll come up against tricky things on the ward' (06-I00.50/06-I29.37). I comment that her bicycle doesn't need side-wheels – this is the independence she has at the end of the programme. Although you can't do the programme in isolation – Isa mentions educators and mentors – she is aware that she has had to do the work (06-I12.38).

We talk about wards where Isa has had placements and where other students have had problems. Isa shrugs her shoulders: 'I've never had problems on a ward' (06-I30.11). 'Everyone is different – I'm very quiet and not in your face with a big mouth ... I give a calm impression.' She starts to mention that a person quickly adapts...but then stops (06-I30.58). Isa starts to talk of how

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<sup>13</sup> 'Doorheen gefietst' – a Dutch expression meaning 'having come through something quite easily'.



she copes with situations when she doesn't feel happy or comfortable: 'I pull back and don't really put up a fight' (06-I 31.42). Isa explains how she did pull back on a ward where the mentorship was less than it should have been. She just kept her head down and got on with the placement. Isa recognises this behaviour and always weighs up the situation before opening up: 'In one situation I thaw faster than another' (06-I31.56). Isa is, at the same time, adamant that she's not subservient and, when she must, is well able to say what she thinks without getting too excited. She is quick to say how at home she feels on her current ward and tells of a situation earlier today in which she reproached a registered nurse for not answering the patient's call bell: 'I would never have done that 18 months ago ... I surprised myself, but I feel better about doing it' (06-I33.11).

The career signpost is pointing one way. Isa tells that if she'd drawn it pointing from left to right it would mean that she'd leave the nursing path ... she intends studying further and as far as she can see now, it will be within the nursing profession (06-I02.14). Isa goes on to say that the reason she went into nursing is that she wants to specialise in Accident & Emergency Care (06-I02.55). The hill after completion of the programme is Isa's realism that the future may not be flawless and that things 'will always still cross your path' – after registration '... that's when your career starts and you have "real" responsibility' (06-I03.53).

Isa tells of how, prior to starting the programme, she was a doctor's assistant working in the plaster room, from where she could observe the happenings in the Accident & Emergency Unit. That was where she wanted to work and the nursing programme was the route to developing new boundaries to her role: 'I find the work hectic and having all senses on sharp, great ... acute things are interesting' (06-I08.24).

I observe that Isa's drawing shows nothing of her history in the programme considering that I'd asked her to draw the route she'd followed and any situations which may have caused her to change direction en route. The drawing clearly shows the obstacles in the immediate future Isa needs to address – namely the presentation of her final assignment, which she's apprehensive about (06-I03.15).

Isa looks back on the programme rationally: 'I could have drawn high hills behind the bike, but I never really had a heavy time of it ... I never really thought that I wanted to stop. But in the second and third years a lot is



expected of you – I found it difficult’ (06-I05.30). Isa goes on to tell about her insecurity as a student – something she’d never spoken about before – if a patient of ‘hers’ was admitted to the Intensive Care Unit, she would be concerned that she may have missed some important observation and that the patient’s deterioration was due to her incompetence: ‘Now you see that I can’t do it.’ The insecurity, she hastens to add, has left her – ‘you grow in it (the nursing role)’ (06-I06.28).

I’m quite surprised at Isa’s confession as she’s never spoken about her feelings of insecurity in this way before. I say so and we both laugh about it, but I’m quite taken aback as her stoical presentation has apparently had me fooled during all the in-depth interviews we’ve had over the years. I question to what degree I can then think of the interviews being ‘in-depth’ and what value I can give the open discussions with other students – are these two behaviours of the students both sides of the same coin ... their sharing with me what they think I want/need to hear?

Nothing dramatic happened in Isa’s case causing her to think differently with regard to her insecurity: ‘There comes a point that you make a click ... you’re busy with it in your mind ... but it’s not really a turning point’ (06-I07.38).

Somewhere in my mind I’m a little disappointed – apparently I wanted some dramatic change to have taken place. But it seems like a form of evolution in Isa’s development rather than a specific occurrence causing her to understand her role, responsibility and boundary as a professional nurse. This is a strange reaction on my part as I didn’t seem to have had any earth-shattering experiences teaching me my professional role, but rather it just seemed to happen ...

I’m curious what the value of the nursing programme has been, if only as a means to an end ...

Isa is clear that following the nursing programme has been valuable. She didn’t have a full idea of what nursing entailed before starting the programme – looking back, it hasn’t been easy and she had to work at it ... it hasn’t simply materialised. The programme has provided her with a good basis from which to specialise. She’s conscious that she probably won’t use all of what she’s learned, but it is a good foundation. She sees working as a registered nurse for 12–18 months as part of that foundation and something she needs to do before contemplating a further specialisation (05-I09.41).



Being in the programme for four years has had a personal effect on Isa: 'The subjects at school allow you to look at things differently' (06-I15.53). She is more self-aware and mentions how she has been confronted with suffering. As a result of her experiences she lives more consciously and tries to get the most out of life. She has also learned to rationalise things: 'Things can always be worse, so what are you making a fuss about?' She has moved away from making a fuss about little things (06-I13.26). Isa is most aware of the change in her personal life and that she makes life simpler by rationalising things: 'It gives me more peace', but immediately adds, 'but I'm also four years older' (06-I15.00).

Recently Isa was involved in her first resuscitation with a patient allocated to her. This made a big impression on her. Previously there had been other 'hills' she had to surmount, such as inserting naso-gastric tubes and catheters, and now it was a resuscitation (06-I16.13).

I'm aware that I'm thinking how rational and seemingly unemotional Isa is in her approach to a situation she maintains made such an impression on her. Am I experiencing the stirrings of stereotyping? Is Isa symbolising what I would consider to be a nurse that 'escapes' to a surgical ward, the Accident & Emergency Unit, the Intensive Care Unit or theatre to get away from having to deal with the emotions of death and dying? But, at a personal level that is not how I see her after all the hours of talk we've shared. Was 'escape' the reason that I moved into theatre for so many years post qualifying? I hadn't perceived my training to be traumatic in any way and also just seemed to do it – is there some commonality between us? Am I looking at myself and finding it quite surprising? Why should it be surprising? Is it surprising? What am I going on about?

Isa continues her story of the patient she'd recently resuscitated but who didn't survive. She realised afterwards that she'd never discussed end-of-life issues with the patient – perhaps the patient wouldn't have wanted to be resuscitated. Isa seems a bit pensive as she says: 'At that moment you just act' (06-I18.26).

I hear Isa talking about other situations that have made deep impressions on her – the first time she found a patient dead in bed: 'I was very scared and in panic – the adrenaline nailed me to the ground ... the second time I was much calmer ... it's the unexpected and unpleasant things that make the most impression' (06-I17.39). 'The important things are those to do with life and death – they're irreversible and definite. The resuscitation was a crucial



moment ... will the patient survive and how will they come through (will they be handicapped as a result)?' (06-I19.00)

Isa tells how she thinks of life and death and that she's aware that life can be over suddenly – a person can meet their end in a matter of minutes (06-I19.55). She goes on to say that she approaches life and death less personally – she has had to develop her own ideas on the subject due to her chosen profession (06-I20.34).

My mind flits back to my stereotypical ideas a few minutes previously. What do these ideas say about me?

Isa continues. For her final assignment she's going to be exploring terminal sedation and feels that there is a lack of knowledge among the nurses on the ward. The patient population on Ward K means that this procedure occurs regularly and there are many publications dealing with associated issues. Owing to the legislation governing end-of-life care in The Netherlands, the judicial aspects can be quite extensive. Isa is intrigued by the ethical dimension of the discussion and is interested in palliative care ... 'It's part of our profession' (06-I21.09).

My thoughts are back with my stereotypes. How is it possible that Isa wants to do an Accident & Emergency Care specialisation, and yet is interested in palliative care? I ask whether the two are not contradictory.

To a degree Isa agrees that Accident & Emergency work and palliative care could possibly be seen as being contradictory (we both laugh): '... palliative care – with so little, you can mean so much to the patient and their family.' Isa feels that some staff members are perhaps frightened or find it difficult to nurse terminal patients, thinking there is so much to do. She doesn't feel that this is the case. Being with the patient has something spiritual – patients think of their past or have thoughts of life-after-death (06-I22.29) ... on this ward patients often return and need crisis management and palliative care: 'The one doesn't need to exclude the other,' ends Isa (06-I23.58).

Isa doesn't fit with my stereotypical image of a nurse 'escaping' from death and dying ... I feel somehow relieved. I realise how judgemental I can be.



Isa is not very involved at a spiritual level but believes in a form of predestination, although she doesn't read about it: 'Sometimes you see things and just know it was meant to be that way.' She tells how she used to think about spiritual things a lot but couldn't really understand them and so let them be (06-I24.40).

I suggest work I have read on how, as nurses, we book spiritual growth through our relationship with patients and how we identify our own suffering with that of the patient and so care for ourselves in the other through a projection of our own (potential) suffering (Levinas, 1991; Eriksson, 1997; Ray, 1997; Watson, 1998; Nåden & Eriksson, 2000; Nåden & Eriksson, 2002). Isa is again rational in her response – this to her has to do with setting personal boundaries. It's important to be involved, but simultaneously to maintain distance: '... it would seem in that case (referring to what I've told her) that the boundaries have gone' (06-I25.35/06-I27.02/06-I27.47).

Isa has wrestled with the distance/involvement aspect of care from the beginning of the programme and tells how she always tried to keep distance. This, however, has not always been possible as there have been patients with whom she identified more than others ... 'someone you know well, or someone your own age. ... But it's not wrong ... I'm also a person' (06-I28.13).



**SECTION NINE**

**Annemieke's 'blue sky' story**

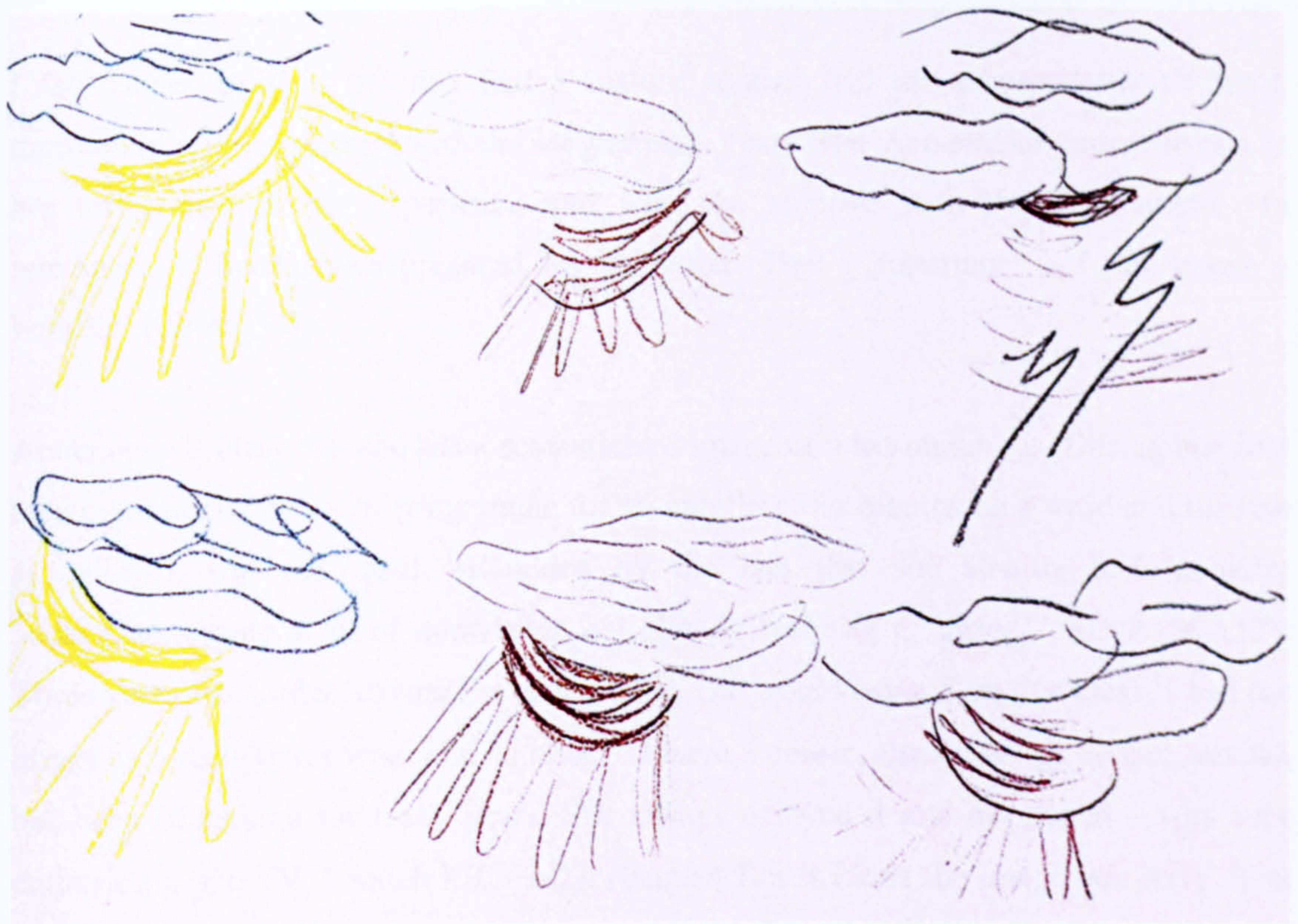


### Annemieke's 'blue sky' story

Annemieke is a mature student who left the programme in June 2004 but who agreed to meet me annually to reflect back on her experience of nursing. We agreed to do this for the length of what would have been the programme she was enrolled in.

June 2006:

'Clouds with sun – the beginning of the training. The clouds became darker and the sun smaller and after a year and a half they were very dark clouds and a very small setting sun with lightning' (06-A3.38). 'This is roughly how it went. Starting the programme with high expectations and along the way – due to all sorts of things, including things you hadn't sussed properly ... that your expectations were different along the way ... and then along comes the man with the hammer and it's done – it's finished' (06-A4.43).



### Annemieke's 'blue sky' story

The fourth sun was when Annemieke stopped and picked up the thread of her life again outside of nursing and the pattern became reversed (06-A5.11). Annemieke says that she's 'very happy now', indicating that she was at the



third sun when things were going badly and that now she's at the sixth sun and it's shining again (06-A6.13).

December 2003:

Annemieke is in a placement on Ward J and is taking part in a focus interview. I start by asking the group what have been important occurrences in the past three to four months of being in practice. I am met with laughter.

'Well ... let's say ... my first death that I was directly involved with. I found that very impressive. And especially the support afterwards from the colleagues. And all the things you see of everything that can happen to people, which I'd never realised' (03-A2-5).

'Also I hadn't really adjusted to people who die. I always had the idea that people come in ill, you help them and they go off happily home – finished. But that's not how it works' (03-A9-11).

I feel rather awed at the fact that a mature student had not prepared herself more thoroughly prior to starting with the programme. Years later Annemieke returns to this in her reflections on her experience and why she stopped with the programme: 'In retrospect, I should have prepared myself better. That's important ... I just chose a hospital' (06-A8.52).

Annemieke is clear that she has a romanticised image of what nursing is. During our first meeting, after being in the programme for 16 months (four months on a ward and the rest at college), she was quite astounded by the fact that she already had 'actually accumulated quite a lot of knowledge – I already feel like a "sister".' (03-A156-157). Three years later, after leaving the programme, she would expand on this idea: 'I had the image as a child that I would be "a sister". I have a cousin, the same age as me, and she has been in nursing for many years. She always enjoyed it and developed – was very enthusiastic. On TV, I watch ER – silly. (laughs) But it forms the image you have. You realise it's not realistic, but still ... I think I wanted to do things too quickly – but you can't, you first have to go down the whole route' (06-A9.35).

During our first interview it appeared that Annemieke's expectations of her role in the nursing profession needed to be specifically practice-based and patient-centred for her to maintain her feeling like a true 'sister' and she would budget her time in order to do 'silly little things' for patients (03-A16).



However, life on a busy surgical ward confronted her with other expectations and taking patients for a walk was 'not the done thing' (03-A18) – 'it was more or less expected of you that you offer your help to colleagues who aren't finished yet and who haven't managed to get their planning together for whatever reason' (03-A21-22).

Illustrating Annemieke's learning in terms of Castillo's framework (1974) (figure 9.1), it would seem that Annemieke's emotions play an important role in this early stage of her nursing career. She is aware of collegial expectations and patient responsibilities, which are, in her perception, sometimes conflicting. She seems to recognise responsibilities from an emotional approach, but she doesn't seem ready to learn to take the responsibility from a position of developing her role towards that of a registered nurse. Annemieke expresses the conflict she's experiencing in terms of it being a dilemma (03-A45). She identifies tasks needing to be done for patients and she identifies the implications of team work. Annemieke doesn't seem able to use this situation to develop her over-arching professional role by learning from the situation, but it rather reinforces her desire to be available and accessible to the patients in her care. It seems to position her in a 'them/us' polarity – the ward staff against her and the patient. Her perception of the registered staff being in an opposing camp is highlighted when she says: 'Look, I just want to pass this course in a good and nice way, and when you have to make a choice not to discuss your frustrations and irritations – then I sometimes choose not to do that. I regret it later ...' (03-A98-100) '... you can quickly rub someone up the wrong way' (03-A104-104).

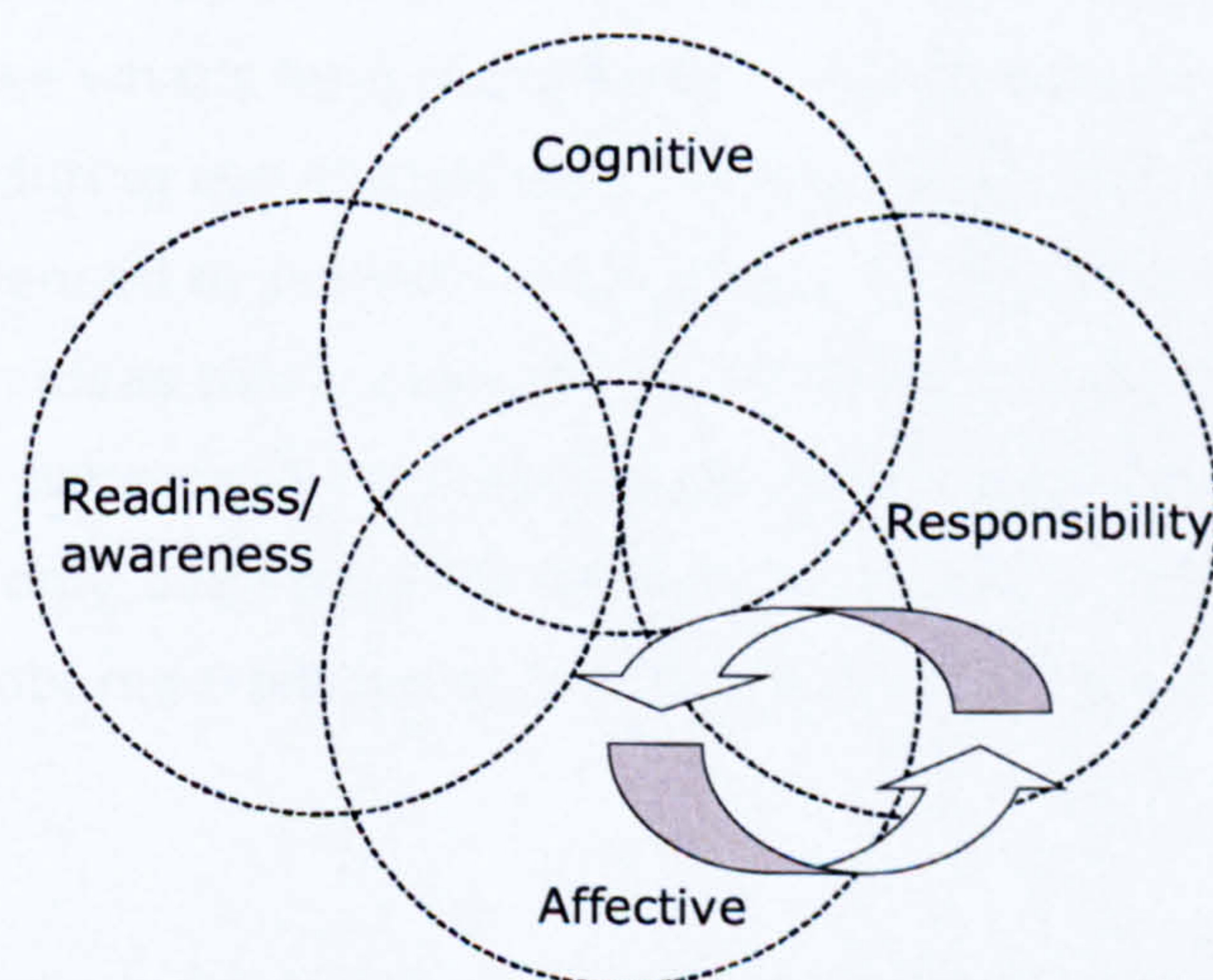


Figure 9.1 Annemieke's learning process (December 2003) illustrated in terms of Castillo's (1974) model

It seems clear from our discussions that Annemieke found the pressure of responsibility quite overwhelming during the first interview: 'And the



responsibility you have. I find it a pretty big responsibility ... certainly for people who are just starting on a ward. You have to carry a very big responsibility' (03-A12-13). She returned to the issue of responsibility in our final interview three years later: '... it's very responsible work ... I mean ... you're busy with people – one mistake and it's irreparable' (06-A10.51). 'In this profession it's quite scary, the things you have to do or the things that you can do wrong – you mustn't think about it too much' (06-A11.15).

When I view Annemieke's learning process on the ward using Castillo's framework in general terms, it appears as though she wasn't ready for, or able to learn from, her experience in the messiness of practice.

Interestingly, Annemieke is very clear in setting her boundaries with regard to 'technical nursing procedures' and easily refuses to carry out any actions she's not confident or competent to do (03-A89-91). I find this a contrast to situations in which she identified psychosocial care for the patient at her level as a second-year student and during our discussion Annemieke is adamant: 'How would I find it to stay in the same room? To stay within the same despair?' (03-A38-39) and finds it appropriate to take the patient for a walk to give him a change of environment. The issue of removing patients temporarily from their environment – to '... do something nice for them' (03-A50), '... it could just mean that you feel just that bit happier if you do something else. Not only the standard patterns the whole day. The routines, the order ...' (03-A39-41) or take them for a walk in the hospital '... to go downstairs and see what's happening there – see something else?' – is raised numerous times during our discussion (03-A16-19, 03-A33-36). And yet she feels too inexperienced to defend her decisions: '... you should be able to put forward your own ideas more. How you think about things, for example, the small things with patients. To actually speak clearly and openly about it. But I also think ... I've only been busy for such a short time ... and, yes ... something prevents me from doing it. It'll just be that I'm chicken. (sniggers)' (03-A80-84).

Although Annemieke indicates that she is strict and secure in setting her boundaries, she identifies situations in which she is given too much responsibility, and too little mentorship, for a student in her first practice placement. She is aware of this, but also feels she can't refuse work as this would mean her colleagues would have extra patients and therefore have too heavy a workload (03-A125-135). She tends to want to compensate for this



by suggesting that she can cope with the situation: 'I am luckily a bit older so am able to deal with it' (03-A138-138), but she also tells that she wakes up at night wondering whether all has gone well. Her focus is on surviving the day and working hard, but worries what the patient's interpretation of the situation would be if they knew (03-A153-155). Annemieke seems to have an issue communicating with the registered staff about things that she's not happy with. She contemplates discussing things during the coffee or lunch break, but doesn't, which she regrets (03-A107) and then also chooses not to discuss it at the end of a duty because she'll be 'going home in a minute and I don't want any drama' (03-A111). This, too, she regrets during the interview (03-A112), but realises this is a choice she has made (03-A115).

Annemieke appears to have assigned her registered colleagues to a 'them/us' polarised position at the start of her ward experience.

There is an element of 'them' being inefficient and the student needing to pick up the pieces '... because normally when you've finished your work for the day, it's more or less expected of you that you offer to help your colleagues who aren't finished yet and who haven't managed to get their planning together. For whatever reason. So it's expected that you do that first, so then zero time is left over to do anything with patients ...' (03-A19-23). '... there are also colleagues who run around with a red face between patients, and, well, I don't know exactly WHAT they still have to do ...' (03-A47-49).

There is also an element of colleagues' being lazy: 'it's often the same colleagues who don't manage to get their work done in time. And then I see them taking a longer break, for example ...' (03-A60-61).

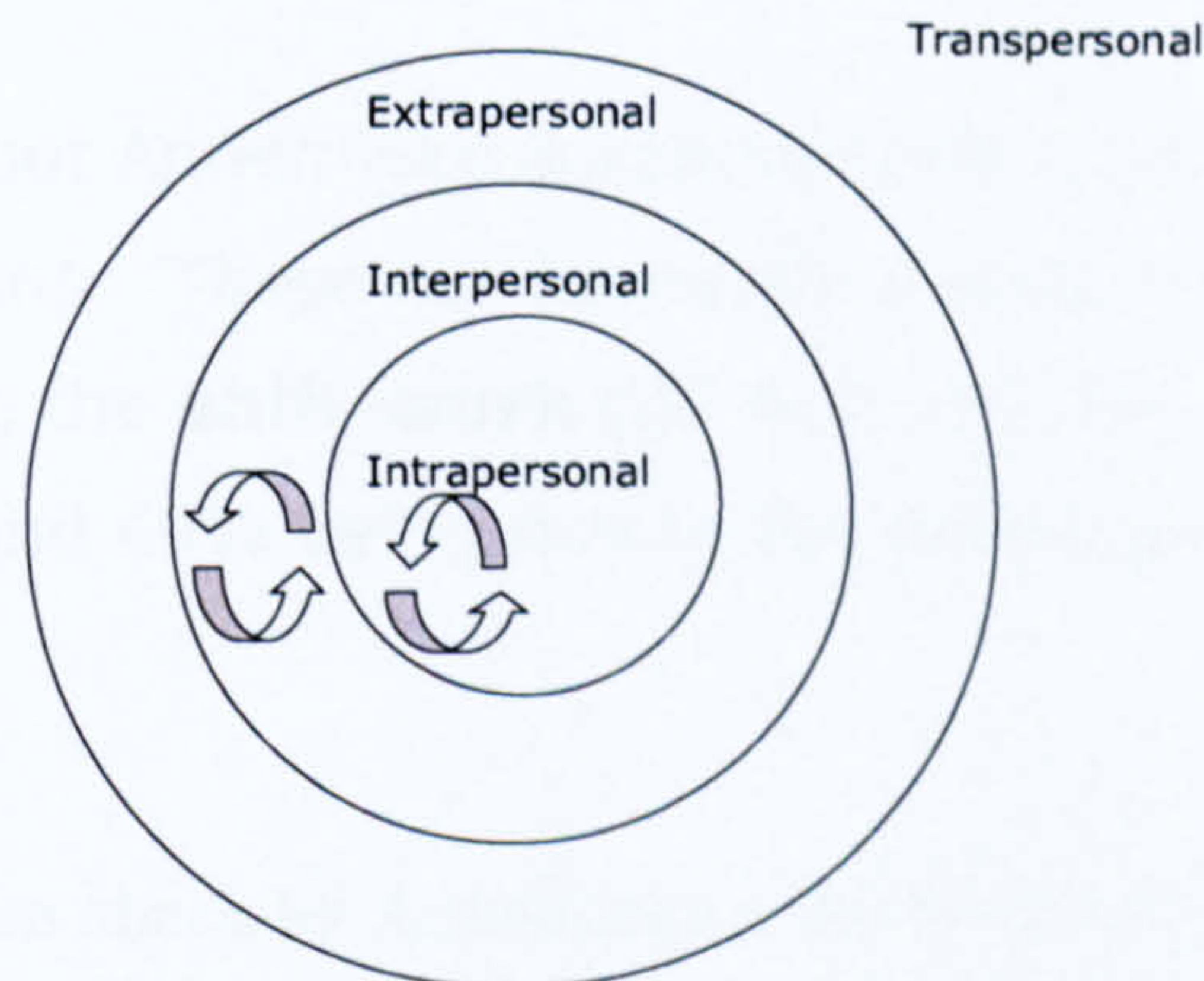
Annemieke is also of the opinion that registered colleagues will pass on tasks they don't like doing to students: 'I know exactly the sort of things I'll have to do. It's very predictable ... I don't always have a good feeling about it.' (03-A64-65).

Annemieke comes across as being defensive when sharing her experiences of the ward staff: 'But actually you should be bloody minded ... I've done my work and now I can reserve time ... something nice for the patients' (03-A23-24). Even though Annemieke is angry with the situation, she doesn't have the courage to address the issue: 'I'm too chicken to say "I'm not going to help



you. I've finished my own work, cheers." No, I'm not assertive enough for that yet' (03-A-51-53).

I ask what the response would be if taking the patient for a walk were to be presented in terms of an intervention related to the psychosocial care of the patient. Annemieke replies: 'I think that if you presented it in that way – "This is my plan" – and if you discussed it ahead of time with your mentor, it'll probably not even be a problem. It'll probably just be accepted' (03-A72-74).



*Figure 9.2 Annemieke's learning process (December 2003) illustrated in terms of the DeMeulle & D'Emidio-Caston (2003) model*

Related to her perceptions of responsibility, Annemieke appears to be influenced strongly by the social and environmental factors on the ward. In terms of DeMeulle & D'Emidio-Caston's model (2003) (figure 9.2), it would appear that Annemieke reflects on the emotions, personal beliefs, values and thoughts of the Intrapersonal Domain, while simultaneously reflecting, in isolation, on the aspects of interpersonal communication, group dynamics and group leadership of the Interpersonal Domain, without relating the two domains. Annemieke is emphatic in her enthusiasm for the work she has chosen, concluding her participation in the focus interview with: 'Methinks I was born for this.' (03-A159) and 'Yes, that gives a good feeling. If I look back to 18 months ago, then what had I been doing all those years?' (03-A160-161)

During the interview there is regular laughter. Although I don't want to read too much into this as it was a first interview, and a focus interview, I do wonder to what degree the three students present were enacting the situation on the wards and wanting to 'please' me. Sharing quite dramatic experiences and being quite judgemental about their registered colleagues, and then retracting their statements using humour. I am curious as to how this will develop with them in the future.



December 2004:

Annemieke stopped her participation in the programme six months ago.

I am, in part, quite shocked at her decision to stop the programme, considering her enthusiasm during our last meeting and her specifically saying that she was in the 'right' place. On the other hand, I'm not that surprised owing to the way she seemed to polarise herself vis-à-vis her registered colleagues. I am, naturally, very intrigued about what will surface during our meeting.

The meeting is friendly but Annemieke is rational and businesslike as she sets out her reasons for leaving. These can be neatly placed into categories – 40% of the reason being the **shift-work** (04-A00.29), 20% being the **travel distance** (04-A00.33) and 40% being due to the **ward culture** (04-A00.37/A17.20).

In some ways I'm quite taken aback by Annemieke's coolness and it seems as though she has almost rehearsed her lines. I ask her to explain further.

'It was busy – that was fine, I expected that, but it was just different to what I'd expected' (04-A09.45). 'I expected to work hard, rather than have periods of the day with nothing to do. It's half-soft, not working with the patients' (04-A09.56). This frustrated her as she felt that she needed to look for work – especially in the afternoons (04-A01.30).

'There are too many things done away from the patients.' The additional tasks such as medication and administration - Annemieke sees these tasks as needing to be done, but they are not part of 'care' provision (04-A10.42). She had expected to be busy with the patient the whole day and not with non-patient-related tasks (04-A10.42–A11.60/04-A40.42). She refers to it as a 'Florence Nightingale' image of what nursing would be. 'I felt like a real "sister" when I had my uniform on.'

It was clear that she enjoyed talking to the patients and spending time with them. Besides not having sufficient time to do this, Annemieke felt that her time with the patient was undermined by other disciplines (she mentions 'psychiatrist' or 'psychologist') needed by the patient. Although she understood and respected the patient's need, she felt 'cheated' out of her time with the patient (04-A32.50).



Annemieke seemed to be basing her experiences on the work she'd done in a nursing home during her first year of study to earn extra money and build up experience – here she'd worked with elderly dementia patients. She refers to this experience numerous times during our meeting and it is clear she wanted to care for people who were dependent on her. She feels she has a 'calling', but then for nursing elderly dementia patients (04-A11.60/04-A31.08). 'The more the patient is dependent and the more you can do, the more care you provide' (04-A14.44) ... 'you can give so much of yourself' (04-A15.13).

Another aspect of nursing Annemieke had not fully realised was that work continues 24 hours a day and 7 days a week (04-A51.31) and life would entail working shifts.

Working the Christmas and New Year period was the last straw for Annemieke (04-A17.43/04-A40.40/04-A43.00) – she found it very traumatic not to be with her family at this time of the year. She had found it difficult to see so little of her husband, who also did shift-work. At first she had thought she would enjoy the freedom, but had never imagined she would so miss being part of the family festivities prior to it actually happening (04-A18.20).

It is interesting that, during this discussion, although she realises that she has underestimated numerous aspects of the nursing profession, Annemieke thought that she had adequately prepared herself (04-A51.31). In the final interview, however, two years later, she realises she should/could have prepared herself more (06-A8.52).

The discussion with Annemieke at this level is focusing on what DeMeulle & D'Emidio-Caston (2003) would consider to be the Intrapersonal domain. The discussion focuses on Annemieke's emotions, personal beliefs, values and thoughts. Although she is quite resolute in what she's saying during the meeting, she seems to backtrack and tries to soften what she's saying by (in my perception) apologising for her position and opinion: 'This is just my viewpoint, but I don't know anything' (04-A05.20), 'but I'm only a student' (04-A04.30); and she seems to seek support from group members: 'Other mature students in the group see things too, but seem better able to deal with them' (04-A16.40).

'Everyone (the nursing staff) is so busy' (04-A01.17) and they seem to have so 'little planning (to their day)' (04-A01.30). 'Everyone is so busy, but it's difficult to break the patterns because they've been working like that for a hundred years' (04-A01.38).



As she had done in the first interview (03-A19-23), Annemieke refers to what she considers to be inefficient work methods: 'I find it frustrating that others (colleagues) don't see that they can plan their work differently' (04-A02.47). 'Between 14:00 and 16:00 you have to look for work because the patient has visitors' (04-A05.09). Students have to pick up the pieces for registered colleagues: 'It's frustrating that you get work pushed onto you from your colleagues – the things you have to do are structurally the same – observations, making beds, etc.' (04-A03.30). But it's not only patient-related efficient and effective work that Annemieke criticises. Punctuality is another issue – coming from a commercial background Annemieke finds it very difficult that staff arrives up to 30 minutes late for meetings and finds this an indication of inefficient time-management (04-A05.70).

Annemieke goes further to say: 'There's no leadership on the ward. No correction.' (04-A04.58) 'Some people in the profession just stay set in their ways (rituals and routines) and there's no movement – as a student you can't change that' (04-A22.12).

Within the ward team Annemieke identifies what she clearly considers to be power issues.

In Annemieke's perception some colleagues didn't seem to have to work public holidays and weekends (04-A19.40) or, if they did, they worked fewer – students would work 2–3 per month whereas registered staff would work one.

Annemieke selectively communicated her observations at different levels on the ward: 'I gave feedback to colleagues about their stressed behaviour' (04-A27.26) and it was well received. And at another level: 'I discussed the inefficient workings of the ward with the ward manager, but didn't dare to discuss it on the ward with colleagues' (04-A27.50). 'I didn't dare, because you want people to like you and otherwise they'll make your life difficult' (04-A28.30).

To my mind Annemieke is discussing aspects such as interpersonal communication, group dynamics and group leadership, aspects contained in what DeMeulle & D'Emidio-Caston (2003) refer to as the Interpersonal domain. Although Annemieke discusses elements contained in the Intra- and Interpersonal domains, there doesn't appear to be a cross-over between the domains.



Viewing Annemieke's ability to learn in the ward situation from what she said during the first interview, it seemed difficult for her to elevate her learning objectives from the basic, concrete and practical to a more abstract developmental level.

This could have something to do with the student mentorship she was getting on the ward at the time. 'The support you had as a second-year student left much to be desired. I don't think the ward staff understood what students had to learn or do and you were placed in very complex and unexpected situations' (04-A39.04). 'I was allocated five patients freshly back from theatre and an admission.' During our discussion it was clear that Annemieke was very aware of the increased risk she and the patient were exposed to if she should try to cope with such complex situations (04-A37.52).

Owing to the complexity of care and mentor/student linking, Annemieke felt that she had too little continuity as she was always being allocated to a different set of patients. It was not the accepted thing on the ward to nurse patients in different rooms simultaneously, so students were always being moved (04-A33.00). She found the changing level of responsibility very difficult (04-A36.56): 'It's a bizarre world and you have to stand with your feet firmly on the ground if you're to get through the four years – it's constantly changing and calls for huge flexibility' (04-A36.56).

The situations Annemieke was coming up against on the ward and her first-year experience in the nursing home could possibly mean that she was seeking her security by trying to 'limit' her activities to what she knew and understood based on her nursing home experience.

Annemieke appeared to have been surviving in the situation by focusing on areas that are familiar to her – reminiscent of Knowles (1980:50), who suggests that adults *are* their experience.

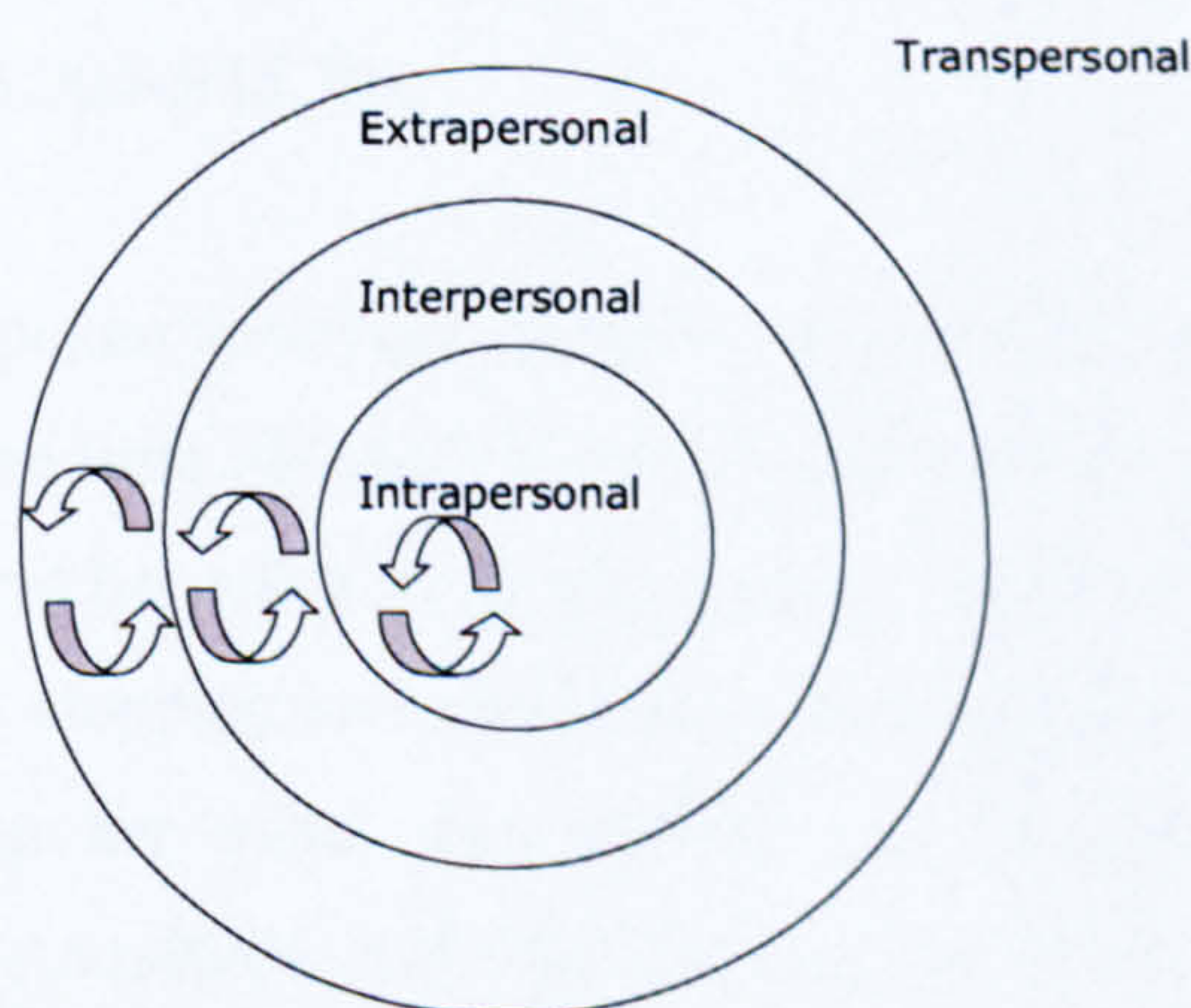
In Annemieke's case, her commercial experience allows her to look at the bigger picture: 'With a good organisation you have a win-win situation' – based on her commercial experience and background Annemieke is adamant that things must change (04-A23.08). 'We (the health care) would need to reorganise due to cutbacks – everyone else has to.' (03-A02.57). 'The services need to be organised differently' (04-A05.46). 'Health care must be organised differently. Not only the ward, but the whole organisation must be



turned around' (04-A24.53). By improving time-management and revisiting the staffing ratios, Annemieke is convinced that this could result in a huge reduction in costs. She feels that if she had been able to complete the programme and work her way up the management ladder, she would have been able to make constructive changes (04-A21.25).

From a managerial perspective she has a number of suggestions for the staff at ward level: 'Colleagues need to start on time – 07:30 instead of 08:15' (04-A03.48), 'have a 15 minute coffee break, instead of 30' (04-A03.52). 'Time is money. Work must be done more quickly and more efficiently' (04-A24.16). 'People's attitude to work must change' (04-A25.37). 'It's important that the ward manager has authority. Start small, but show that it works (efficient and effective work and time management) – be an example' (04-A26.13). 'Show the many advantages' (04-A26.40). 'There needs to be a clear policy about efficient and effective work. Always address confrontations immediately' (04-A27.12).

It is clear from Annemieke's comments that she is addressing aspects of DeMeulle & D'Emidio-Caston's (2003) Extrapersonal domain, namely organisational dynamics, professional standards, educational issues and the 'societal' norms of the group involved. Underpinning her passionate critique of the health care she'd been party to is, to my mind, a greater passion for the most important stakeholder in the system – the patient. She refers again to her nursing home experience: 'That was really busy (working with elderly dementia patients), but I feel better (working with this category of patient) ... the patients in hospital can communicate their needs ... working with this category of patient in a nursing home is "real care" and as a nurse you can do good work' (04-A06.40-07.33/04-A09.26).



*Figure 9.3 Annemieke's learning process (December 2004) illustrated in terms of the DeMeulle & D'Emidio-Caston (2003) model*



It appears that Annemieke is aware of elements contained in the Intra-, Inter- and Extrapersonal domains as described by DeMeulle & D'Emidio-Caston (2003), but she deals with the issues in isolation without integrating them into a single process (figure 9:3).

She seems to return to the emotional level of the Intrapersonal domain when thinking of her current situation in terms of what she'd left behind.

Having left the hospital, Annemieke considered working in a nursing home and possibly doing a lower level programme, but that wouldn't have solved the other factors she didn't like, such as shift work (04-A08.22). Once she'd stopped nursing, Annemieke missed the nursing home rather than the hospital work (04-A08.42). After experiencing two wards (Ward H as a fragmented, ten- week placement in the first year and a number of months on Ward J as a beginning second-year student), she thinks she could have been too hasty in her decision (04-A16.00). 'I get edgy when I see medical programmes on TV' (04-A08.10). However, a bit later she comes back to that idea and seems content with her decision: 'I'm not sorry and have no remorse' (04-A12.35). 'I tried, but it's not for me' (04-A12.50), 'I'm rational and level-headed about it and once I've decided I come to a quick decision' (04-A 12.50). 'I think I made the right decision' (04-A13.32).

Working in the hospital cost Annemieke a lot of energy and there came a point when she had difficulty in motivating herself to go to work. This was largely due to the fact that she found too little satisfaction in the work she had to do on the ward. In addition, between the travelling time to and from work and having to work over the festive season, she was becoming very unhappy (04-A40.43). She was exhausted from the travelling (05:30 departure every morning) and she was unhappy at work, which was having an effect on her home life (04-A41.10-44.32/04-A43.30).

Annemieke had initially not spoken to anyone about her decision to stop, although she'd been thinking about it for some time (04-A44.19). One weekday she was alone at home and took the decision to 'phone her sister to go out together for the day. Once with her sister she announced she was stopping and called the ward manager to say she wasn't coming back. She'd made up her mind, was resolute and immediately stopped her hospital work (04-A39.44/04-A41.40/04-A45.14). She took the weekend off and had a meeting with the manager and practice educator on the following Monday morning, but had already written her letter of resignation the previous Friday (04-A45.14). Once the



meeting was over, Annemieke tells how she treated herself to coffee and cake, enjoying her freedom (04-A47.21)

Looking at nursing from a distance, Annemieke sees nursing home and hospital-based nursing as different worlds. If she could choose again, Annemieke would opt for the nursing home (but the negative point of shift work weighs too heavily) (04-A48.00). In retrospect she hadn't realised that people would actually die, but realised that as you get more experience you learn to deal with it more easily (04-A52.25). She found it very difficult that people of her own age died and identified strongly with the patients and their children. It's heavy for the nursing staff – 'I found it very heavy' (04-A54.00). 'I became very emotional with dying patients – I would howl. But colleagues were so understanding' (04-A54.58).

'Not being in control of the situation played a big part (in not continuing with the programme). I'm normally very sharp, so I found it very difficult not being able to answer the patient's questions' (04-A38.44). 'It's probably easier for younger students – they have less baggage to carry (life experience), it's a lot more difficult now' (04-A-20.51). 'If I'd started ten years ago, I would have had less rubbish to carry with me' (04-A24.30). 'It's such a pity that I wasn't able to carry on – a pity for future patients and a pity for me. I could have offered so much' (04-A55.58)

I found this an emotional interview. On the one hand, Annemieke represents a 'failure', someone who has entered the 'inner sanctum' of the profession, but then has left with secrets they can share with others outside the group. I feel in a way betrayed and shocked at what may be 'leaked'. What does this say about me? Yet I feel uneasy as I identify with all manner of emotions and challenges Annemieke has expressed. I think of my own relatively new work circle and identify with the feeling of being powerless and wanting to leave. I admire Annemieke. I feel the pressure of the tail between my legs, while she seems able to hold her head high and walk away with pride. I think of Knowles' Dimensions of Maturation (1980). In some ways Annemieke falls short – altruism, for example, I think bitterly – but then I think of the other dimensions such as autonomy, activity, objectivity, responsibilities and broad interests, for example. I feel ashamed – why am I staying where I am and not 'daring' to move, although at the moment I'm very unhappy at work I'm not daring to move and feel quite powerless to do anything. I ask myself: Who is the more mature: the one who leaves or the one who stays?



December 2005:

Annemieke and I face each other again and neither can believe that a year has passed since our last meeting.

Annemieke has been in a new job for more than a year and all is going well (05-A00.20). She's working as team leader in the customer complaints department for a national organisation (05-SA00.43) and says she's comfortable in her new job with its clear leadership and management structure (05-A01.10).

She tells that the new job is bureaucratic and that it's difficult to introduce changes due to staff not rotating – during our discussion we laugh, recalling Annemieke's issues with the bureaucracy of the hospital, and recognise the comparison between a large commercial company and the hospital (05-A2.58/05-A4.35/05-A5.00).

Annemieke tells that she's never regretted stopping her training and that it was a good decision on her part (05-A00.37/05-A29.20/05-A57.28). In some ways she thinks she should perhaps have been more patient and tried to address issues (05-A29.08), but also admits that she would never have lasted long enough to reach the level that would have allowed her to effect change (05-A29.45): 'It would have cost me too much energy to adapt to the situation – I think too much' (05-A56.55).

Annemieke hasn't lost her motivation to care entirely and in her spare time she is developing a service to support older people. The intention of the organisation is to visit them and take them out, to fulfil the needs of the older person in a non-medical capacity, perhaps assisting with their administration, a more social approach (05-A58.21)

Annemieke laughs. She is convinced she will be telling me the same story as a year previously. She enjoyed the first year of training (05-A03.25): there was clear leadership by the practice educator (05-A03.33), she was in a 'nice group' of fellow-students (05-A03.40) and had friendly colleagues (05-A03.45). The most positive memories she has are of the contacts with the patients (05-A39.29), providing care and making sure that the patient was comfortable (05-A39.52), and the lessons with the group at school (05-A40.03).



We discuss the ward culture and Annemieke is no less passionate about the patient being the focus of care than she was a year ago. 'The nurses come across as being cool and task-oriented' (05-A45.58). 'Why read medical books on surgical procedures when you could sit and talk to a patient about their experience of being a patient and probably learn more?' (05-A46.31). 'Why not sit and talk to a patient who gets no visitors?' (05-A45.24). 'I don't understand it,' says Annemieke, 'it (the attitude) fits this world, but not my world' (05-A22.46).

Referring to everyone being busy: 'There's no comparison between the workload of the nursing home and the general hospital. It's much busier in the nursing home. All should be exposed to working in a nursing home ... then they'd see what hard work is about' (05-A27.12).

Annemieke reflects on the nurse/patient allocation 'sweet young girls allocated to very complex patients – it was very unfair, but not questioned' (05-A23.35). 'There is an unequal allocation of staff regarding the heavy patients. It is difficult to assign complexity as it is very personal' (05-A09.22/05-A14.10). We talk about the concept of complexity being subjective and Annemieke is the first to say how difficult it is. But she nevertheless feels strongly there should be better linking of students to registered staff – 'someone should have an overview of who can be allocated where ... I missed leadership and the management of staff – it was too ad hoc' (05-A10.11/05-A10.51/05-A11.16/05-A11.31/05-A11.51).

From top-down work allocation our discussion moves to the autonomy you should expect from a professional person. Some nurses seem to have a very laid-back attitude in getting started with their work and then taking coffee breaks when it suits them (05-A09.36) while other staff clearly took responsibility for the patient and were busy all day (05-A09.42).

'The primary task of patient care and a quick patient turnover is overshadowed by other issues' (05-A07.31) such as making duty rosters and meetings (05-A08.31), 'but even within the meeting culture there's no time-management – can you imagine what it costs for a group to wait for 15 minutes before being able to start' (05-A08.45). 'And reading the reports ... I don't know how long you can take, but some people read for an hour.' (05-A08.56)



From Annemieke's perspective the staff appear to have autonomy to organise their work differently ... maybe the wrong kind of autonomy, but perhaps they 'choose' to be 'too busy'. At one level, however, she doesn't understand their underlying reasons for accepting the responsibility when they are clearly overstretched (05-A14.10), and feels that they have a responsibility in this, but missed initiative and assertiveness on their part to ask for help (05-A12.27). At another level Annemieke identifies that the ward culture doesn't seem open to people 'sticking their necks out'. 'You don't dare to set boundaries if you come into the ward at 18 or 19' (05-A15.38) – though Annemieke indicates that she didn't have an issue with this as she was a lot older.

Annemieke wants me to understand: 'You enter an established order' (05-A15.43). 'The established order has an air of self-confidence ... they know what to do, what's going on and know everything about medication ... that was also so scary ... the medication ... you walk around with a big book ... (shudders).' Annemieke realises that there's a difference between an established order and someone having self-confidence but sees this as a nuance (05-A16.15 /05-A16.35/05-A17.35). She goes on to say that it's normally the older nurses who have been on the ward for a long time who make up the established order. 'It's not possible to question the status quo as a student without knowledge and experience' (05-A17.41) – 'these nurses are not open to being challenged' (05-A18.20). 'You need self-confidence to challenge' (05-A18.30).

I want to know how she knew about the 'established order': 'You know the hierarchy on the ward (without it being explained to you) – the way they present themselves (05-A33.47), their behaviour (05-A33.50), the game you play (05-A34.00), the role playing (which Annemieke says she doesn't do well and is not a part of her make-up) (05-A34.07), their attitude (05-A34.20) and they 'just radiate' authority (05-A34.25). 'The established order manifests their authority visibly and by making comments' (05-A34.47). 'It's the tone of voice and the self-confident and dominant attitude' (05-A36.32). 'It's the dominant role on the ward that sets the tone' (05-A35.09). But, according to Annemieke, the dominant role on the ward is not the same for everyone – there's a difference between the younger and older students (05-A35.41). As an older student, it's your first impression that makes whether things will go well or not (05-A37.45). 'If you make a good impression, you'll get a good (positive) assessment ... it's important that people like you' (05-A38.51).



Annemieke equates the nursing culture to a large commercial organisation and concludes that the dynamics are not really that different (05-A39.14).

Annemieke links the role of the dominant staff and any confrontation with them to her assessment on the ward (05-A37.00). This was different with the practice educator, who treated all students the same and gave clear and direct feedback (05-A38.26). Quite suddenly Annemieke becomes emotional when talking about the power issues on the ward (05-A18.43) – it impinges on her feelings on justice (05-A19.13). She finds it (the organisation) unfair and not thought through (05-A20.15/05-A21.22) – this is especially true of the rostering of students and registered staff over the festive season ... and it seems to be accepted by all. (05-A20.18/05-A21.26). Still, Annemieke can't understand the reason for having to work over the festive season and not being allowed to take days off. The workload on the days she had to work was not in relation to the number of staff on duty at this time – Annemieke found it a waste of time coming in to work (05-A20.29).

Listening to Annemieke, the situation seems to be nothing short of a show of power, rather than being an effective and efficient use of resources. The discussion feels as though it's taking a different turn when Annemieke addresses the issue of rostering. This was an important issue to her, as she had told a year previously that her rostering over the Christmas period had been the straw breaking the proverbial camel's back. Some staff members on the ward were always rostered for night duties or weekends (05-A23.04), but 'I didn't discuss it because it didn't concern me' (05-A23.14).

In another situation a level-4 nurse (non-degree level) who was employed on the ward took her full complement of complex patients and supervised level-5 students (degree level) but wasn't eligible for professional development programmes due to her not having a degree (05-A24.00) – Annemieke feels that there should be some form of valuing the work the staff does, regardless of their levels. 'It's so unfair.'

A number of times during the discussion Annemieke seems to back down, as she did during the previous meetings: 'I only experienced one hospital, so I don't know if what I've seen is the reality' (05-A04.28), but at times she also seems angry and sarcastically negates her opinion by saying that she has no right to talk as she was 'just' a student (05-A26.07). Unexpectedly, a number of times during our discussion Annemieke starts crying: 'If I'd started 20 years earlier, it would have been different ... when I think of the



patient' (05-A41.08) (becomes emotional 05-A40.55). Annemieke tells that she never cries and finds this quite shocking (05-A41.22) – she can't explain the emotional response (05-A41.42). A little later ... 'I have distance from the experience, but once you start talking about it the emotions come ... apparently there's still something there ...' (05-A01.01.45).

Very soon Annemieke focuses on the hospital organisation: she finds it 'unbelievable that so much money is wasted in the hospital' (05-A04.02). 'As someone from outside the culture you see things going wrong, but don't have the power to change things' (05-A05.25). She missed the ward manager having 'more authority' (05-A31.15) and discussed this with him when she left the ward. Her most negative memories are, therefore, related to staff management and are not patient-related in any way (05-A40.29). As she had suggested a year previously, Annemieke is clear that you need to start small at ward level with a strong leadership personality: 'You need a platform to change, namely the workforce at the bedside' (05-A06.16), but also 'you need to be more commercially minded' (05-A06.31) – 'I would go through the ranks with a blunt axe (be ruthless)' (05-A06.51). We laugh at the blood-thirsty imagery within a 'caring' environment.

'You have to remember that you're a "nothing". A little "zero". You have too little knowledge or experience to say anything' (05-A55.14/05-A55.51) ... 'Experience provides authority to question the status quo' (05-A56.22). Having come from being an experienced worker in another field, Annemieke found it very difficult to lose her independence and is clear that her feeling of helplessness was linked to her having to be dependent on others (05-A55.37). She had given an example earlier in our discussion where she'd made a decision, but it wasn't appreciated that 'I took a patient (amputee who was depressed) for a walk in a wheelchair rather than cleaning the sluice' (becomes emotional) (05-A47.17). 'I can't remember exactly what was said, but I recall my feeling that the activity wasn't well received ... with the expectation of one nurse who complimented me for doing it' (05-A48.04).

I question whether Annemieke could have been better supported and whether that would have prevented her from leaving the profession. She's doubtful whether anything specific could have been successful ... she would want the focus (of the profession) to have been more involved with the patient (05-A44.29). Furthermore, from an organisational vantage point, she thinks there could have been a different system of staff planning and an investment in



administrative staff to allow the nursing team to remain patient-focused (05-A44.40/05-A45.16), and in general the organisation was too unstructured (05-A45.00).

Annemieke is quick to stress: 'I didn't miss anything specific in the mentorship – I was always linked to someone' (05-A49.48). 'I felt happy with the mentor in the first year' (05-A50.59), 'but as time went on it became more difficult' (05-A51.48). But she adds: 'I discussed the issues with group members (about accepting the situations on the ward) and we laughed a lot about it (05-A52.53) ... especially with the older students in the group ... but they seem to be happy with it and can accept things ... I can't' (05-A53.30). Annemieke tells that she's very ambitious (05-A54.21) and that she seems to be more advanced in thinking and analysing organisational structures due to the experience she's had in the commercial world ... 'I can't seem to put this to one side' (05-A55.01).

Annemieke indicates very specifically that she is not disillusioned with nursing (05-A52.07/05-A50.32), but it (nursing) didn't come up to her expectations, perhaps through naivety (05-A52.13)

This has been an unexpectedly emotional interview. Discussing this, it emerges that Annemieke's outpouring of emotion during this interview is due to feelings of helplessness (05-A30.30), frustration (05-A30.45) and questioning 'why things have to go this way' as she believes everyone has good and positive intentions (05-A30.51). 'My focus was idealistically on the patient – the reality was different' (05-A41.52). 'I'm disappointed' (05-A42.00). 'There was no space to talk to the patient' (05-A42.15) ... 'You were expected to read a book on the patient category' (05-A42.21).

'I was so disappointed at the extent of non-nursing activities' (05-A43.05). 'My idealised image of nursing wasn't right ... it didn't fit into the hospital ... I was going to become Florence Nightingale ...' (05-A43.24/05-A43.50). Annemieke has no regrets that she's discontinued the programme, but in retrospect she wishes that she had had more patience – 'I would have meant something to the patients ... I could have been a loving nurse' (becomes emotional) (05-A57.13/05-A-57.22/05-A57.42/05-A57.57).



June 2006:

Now, two years after withdrawing from the programme, Annemieke has chosen a job with security and is in the position of managing the commercial sales department in a large national organisation (06-A6.56). Pointing to the first sun in the drawing, she says: 'That's where I sort of stopped ... here ... and I'm back there (pointing to the sixth sun). It's a permanent job and I enjoy it. Great.' (06-A7.15)

Our final interview is shorter than any of the others, but is again quite emotional at times. It seems to have been cathartic to discuss Annemieke's experience annually. She now seems able to integrate her brief, but sometimes dramatic, nursing career into her life-experience.

I try not to lead the discussion by posing suggestive questions, but I'm curious and ask whether the fifth and sixth clouds symbolise the distance she's taken from the situation, allowing her to rebuild her life. In other words, does the sky get bluer as a result of her having had the experience? Or does it get blue due to her filling her life with other things? (06-A31.06) Annemieke: 'I'm very happy with the experience – I don't see it as a waste of time. It has been good for something. It's also a relief when I see a programme on TV or read a newspaper report – I don't doubt that I should have tried it (nursing)' (06-A32.29). 'It was an experience and I can just carry on with my life now because I've experienced it. I keep special experiences from it (the time)' (06-A33.13).

December 2006:

In writing this I'm reflecting on Annemieke's journey over the past years and must conclude that it's been a remarkable journey for her, but also for me. In research terms Annemieke would be the 'deviant case study' in my research. What odd terminology that is? Talking with Annemieke has allowed me to reflect on my own position and role and question why I stay where I am and what the alternatives are. She has helped me to view my reasons for living a profession differently and to question what professional behaviour is.

Many of the issues discussed in previous meetings are discussed again at our final meeting but Annemieke seems to have gained insight ... or perhaps she's more willing to share it with me ...

'You have an image of yourself ... I'm not as social and flexible as I'd like to be ... you get feedback from people around you, but it sticks ... and when you hear examples I



realise that my egoism had a role in it (failing) ... and it relieves when you accept that' (06-A26.03). 'The realisation that although we may want to do things, if we don't have the capacity ... that's it. This acceptance also gives you blue skies' (06-A25.57).

'The 18 months have had more of an effect on me than I could have anticipated or expected. An impact in the world of care, the responsibilities, the illnesses, the unhappiness you see ... it's not something that you can just shake off your sleeve' (06-A27.15). Annemieke leans forward and looks me straight in the eye: 'you understand the impact this has on someone starting out on their training ... so for God's sake keep your eyes and ears open with new groups and take the time for them' (06-A34.03). '... Make sure that people know what they're letting themselves in for' (06-A34.50).

I feel this as a weighty responsibility, but I have my own interpretation of why there were slight clouds in an otherwise blue sky ....



## **SECTION TEN**



### **Closure ... or new beginning ...?**

I find it difficult to shake off the sound of Annemieke's plea for me, as an educator, to look out for students. It is a scary idea. What does this mean for me and what would it mean for students? At the time of writing my thesis and bringing my study to the point of submission, and after having heard of it many times, *The Alchemist* (Coelho, 2006) ended up on my bedside table and made a deep impression on me – a (symbolic) journey searching for continually changing and eluding dreams, goals and happiness until the main character, Santiago, comes full circle to finally understand where his happiness lies. I believe that situations cross our paths in order for us to learn – if it's not coincidence, could it be synchronicity that brings us to where we need to be at the right time? I do not see Annemieke's failure to complete the programme as a failure for her or the system, but as an enriching process she needed to experience in order to move forward. I believe we are each at the place we need to be at a specific time if we're open to learning. This is also true for the students completing the programme – all speak of a calling or predestination of some sort. I think of how Olga, Marijke, Isa and Linda have all, in their own ways, spoken of their entry into nursing as a calling or a form of predestination – even Annemieke felt that she was answering a calling to become a nurse. None, however, spoke of their entry into nursing in the form of a religious calling. Common to all their drawings are light, colour, warmth and direction. So, if viewed from the approach of predestination and being in the right place for what you need to be doing and learning, would it be moral or ethical to alter that course? In fact, a question that arises in my mind is whether any action on the part of the educator could not, in terms of this argument, be seen as being part of a predestined path for both parties. I do believe that it sometimes seems that the courses of our lives are altered by those we meet ... but then again, perhaps these are exactly the people we need to meet on our life's path in order for us to confront our destiny.

Looking back on my life, it's odd to see the winding path that has unfolded in the past 50 years ... life in four countries and on two continents that led me from Bulawayo to Bournemouth. Is it coincidence that these five individuals agreed to be participants in my study, when four others agreed and started but then dropped out and the rest of the cohort wasn't interested or prepared to enter into this four-year journey with me? I can't really believe that I chose the students – I think, rather, that they chose me ... or maybe at a deeper level we chose one another. I also feel that the students who didn't choose to participate, or who dropped out of the research, each have their story to tell and possibly mirror the reality of student numbers prepared to reflect at a deeper level. We'll never get a comprehensive answer to this question, but it is well worth a moment's reflection ...



### **Contribution to new knowledge**

**The first aim of my study was to explain the individual's motivation to enter/study nursing from an adult learner perspective with a view to self-actualisation and the motivation to care.**

What better explanation for motivation than a feeling of calling or predestination? Or is that too simple – ‘an easy opt-out’ is probably what Peter would say. Naturally I could go into great depth and detail about underlying reasons for the motivation, but that is not where I've wanted to go with this study. Besides, the limited insight I have, based on a number of in-depth interviews and written reports and assignments, is just the tip of a personal iceberg the individual has been prepared to show me – therefore I can't talk about an individual's co-dependency, potentially dysfunctional behaviour or self-esteem issues. I feel this goes too far and becomes judgemental. I've also purposely not included demographic details of the participants as that, to my mind, would be a temptation to pigeon-hole their responses; I have rather presented a series of snapshots that are linked inextricably to provide, as it were, a moving image. The participants have, themselves, contextualised their own moving images through their drawings. I don't want to make sweeping comparisons or generalisations but will flag up commonalities between our stories to provide insight into individual journeys over a period of four years as I see them.

As a researcher I have felt enormously privileged, but at the same time a huge responsibility, to present the stories as accurately as possible and there have been times when I've found this process quite paralysing in its enormity. The complexity of dealing with narrative has been very confronting – the speaker (participant) filtering the information they're prepared to share with me and placing it in a logical beginning, middle and end format for me to understand. I (the listener) filtering the stories even more and, through my life experiences, making (conscious and subconscious) choices when reporting the student experience. I apply my own system of plots, beginnings, middles and ends for the reader, ultimately, to do the same (Scott, 1997; Frank, 2000; Holloway & Freshwater, 2007). My personal journey can, in part, be illustrated by the fact that quite early on in the study I stopped referring to the students as respondents and made a conscious decision to call them participants instead – I found that this terminology implied a more active involvement. My positioning was moving from one in authority to one of equity, of sharing a remarkable journey with remarkable people and realising that I simply happen to be at a different place on the same path of life.



The idea of needing to walk a specific path in order to fulfil full potential leads me to look more closely at **another of my research aims**

**the way the student develops a ‘caring philosophy’ as a route towards self-actualisation.**

Besides dealing with the challenges of a new job, dealing with patients is, in itself, a stressful situation for a nursing student but it is in working with patients that students learn to understand what it means to be a nurse in all its fullness. However basic and intrinsic to nursing it may appear, students are, at first, afraid to actually work with patients. Their anxiety about making mistakes or (inadvertently) hurting patients is based in their moral approach to their new profession (Smith & Gray, 2001b; Elliott, 2002) and being confronted by professional norms and values (often interpreted in specific ways by the various ward cultures) presents the student nurse with moral dilemmas (Randle, 2002; MacIntosh, 2003) and adds to the level of stress.

I feel that this initially human response to ‘doing good’ emphasises the fact that nursing has, in essence, a moral base whether it is based on spirituality (Tanyi, 2002), personal reflection and reflexivity (Johns, 1998; Nåden & Eriksson, 2000), professional codes (Esterhuizen, 1996) or philosophical models (Widdershoven, 1999; Esterhuizen & Kooyman, 2001), although the distinction between these various approaches is not always clear.

What has become clear to me through my research is that the process an individual undergoes from student to registered nurse status is hugely complex. It also appears to be important to support nursing students to maintain and develop personal and professional norms and values with regard to their chosen profession. This support may allow them to challenge and discuss the status quo and provide a positive basis for the integration of knowledge obtained via the nursing programme.

When confronted with the realities of work in the clinical setting, students can lose touch with their personal values and losing touch with their personal values can lead to alienation from themselves. Isa, in fact, identifies this exact risk in one of our interviews (page 159). Helkama et al. (2003) discuss a decline and changes in moral reasoning during the education of medical students, while Greenwood (1993), Allcock & Standen (2001) and MacIntosh (2003) discuss possible desensitisation that student nurses undergo during their education which could have strong moral implications for the quality of care delivered. In the case of the participants in my study who completed the programme, although they adapted initially to ward cultures, they always seemed aware of the fact that they were adapting to something



they didn't agree with – they seemed almost to have a strategic approach to their development and the points at which they extended and/or set their boundaries. I do, however, feel that this had to do with the discussions we had in a one-on-one setting – I see a marked difference between the depth and analysis of their critical incident reports which, to my mind, are largely descriptive and the quality and depth of dialogue we engaged in when discussing the same situations they'd written about.

With regard to self-actualisation, the students who completed the programme seemed, from a point roughly midway, able to differentiate good care from bad and were aware when they were compromising themselves as individuals and professionals. They were able to deal with problems and challenges as they arose without personalising them and in some cases it was quite clear that they weren't prepared to invest energy in situations they thought were not worth the effort. By the end of the programme the students had become autonomous and self-sufficient and all articulated a change in their level of communication with others. They were aware of their own boundaries, seemed unprepared to compromise their professional integrity and were self-confident and assertive to challenge. The above-mentioned characteristics, exhibited by the students at the end of the programme, correlate with work by Maslow on self-actualisation (Boeree, 2006). Knowles (1980), in his work on the dimensions of maturation (table 2.1, page 28), discusses an individual's move from superficial to deep concerns, moving away from a focus on particulars towards a focus on principles and from impulsiveness to rationality. This, to my mind, parallels Maslow's idea of differentiating between good and bad from a professional perspective and being unprepared to compromise personal and professional integrity. The students' ability to deal with problems and challenges illustrates their ability to objectify situations and think more broadly, accepting ambiguity and making choices to invest in dialogue they perceived was important. They had become more autonomous in their decision-making and enlightened in their view of the world – in other words, they seemed to have integrated their self-identity and were more self-accepting of their abilities, strengths and weaknesses. They had become self-aware and were able, but also confident, to articulate their personal growth. I was particularly aware of the participants' growth in self-confidence and remember wondering to what degree they were saying things I wanted to hear in order to 'please' me during the focus interviews. These doubts have certainly been dispelled in the four years I've been meeting with the students. It is clear that they have become more able and confident to share their experiences and, reflecting on personal experiences, 'pleasing' seems part of investigating and giving meaning to a new situation and devising a strategy to deal with new role expectations.



I was curious to understand

**how the individual copes with internalising professional values whilst undergoing a transformational process,**

**another of my research aims.** The literature I consulted suggests that the phenomena of dependency and adapting to situations and professional norms, on the one hand, and developing self-esteem, self-confidence and independence, on the other, need to be explored more fully and that the way in which nursing students actually cope with the situations they encounter needs to be investigated. Although initially agreeing with this approach and the need to understand the student psyche more fully, I now doubt whether this is attainable or perhaps even desirable.

First, I think that we, as educators, would be attempting to oversimplify the hugely complex and unfathomable phenomenon of student (human) psyche and, en route, run the risk of losing the power of contact with the individual. I am aware of the educator's work pressures and time restraints, the overfull classes and the mass lectures – I am part of the system. I was asked to provide group supervision to 20 first-year student nurses and allocated an hour per week. Anyone with any knowledge of supervision realises that the group is too big and the time too short to deal with any issue in any amount of depth (Bishop, 1997; Bond & Holland, 1998; Driscoll, 2000; Freshwater, Esterhuizen & Walsh, 2006). In the same setting I was involved in developing an undergraduate curriculum in which we attempted to integrate 'true' clinical supervision but, ultimately, due to limited resources, the content was reduced to what it had been in the previous curriculum. This lip service to provide psychosocial–emotional support is similar to the way in which students spoke of wards using clinical pathways; where production figures were paramount and the priority of individualised patient contact diminished and largely disappeared in the ward philosophy and work ethos. I feel that by relying too heavily on theoretical constructs and less on individualised contact in an educational setting, we would accentuate the risk that educators (*with the best intentions*) pick up on certain (theoretical) aspects of the students' psyche (which is a reflection of the educator's own position *in their development*) in order to meet the demands of work pressure.

This discussion makes me remember a time when I shared an office with two lecturers who sent students away if they needed support without an appointment and treated them as small children in front of other staff in the office; making the student stand on the opposite side of the desk, listening and talking, while continuing to mark other students' assignments. And, at other times, discussions in the staff room in which student issues were either seen as being



humorous or viewed as examples of insolent behaviour. I saw no respect of the privacy and/or dignity of the student, yet these same staff members became indignant and defensive if we discussed the (lack of) priority afforded to reflection, reflective practice, reflexivity and clinical supervision in nurse education. I think, looking back, that part of my non-response to the situation was my need to fit into a new group of colleagues – in this case, lecturers. I found myself re-enacting this pattern of non-involvement some years later when, again in a relatively new group of colleagues, I sat by silently as a male colleague viciously abused and attacked the female line manager verbally. Common to both these scenarios was my apparent need to follow the group dynamic. As no one else in the group challenged the situation, I felt angst and wanted to protect myself from any abuse possibly being turned on me. In both situations I clearly remember thinking, to a degree, that the situation had nothing to do with me. How wrong could I be ... I was privy to these overt examples of power display and yet said nothing ... silence is also a form of abusive power (Farrell, 2001; Hutchinson et al, 2006).

Secondly, I now doubt whether it's the anonymous nursing culture that keeps nurses in the oppressed position as described in the literature. Is the way many of us, now in management and educational roles, have been socialised not exactly the issue to be addressed around the socialisation of neophytes? Should we not be the ones breaking the cycle of oppressive socialisation that is described in the literature? I considered myself to be open-minded and committed to promoting empowerment and emancipation; however, the past four years have caused me to question the degree to which I have been open to the issues of students or colleagues, or whether I have been more involved in my own deeper preoccupations. This process has been a wake-up call for me. Am I/are we able, within the restraints of our own psyche, to allow the natural talents of the individual student or colleague to emerge and support and nurture them to a point of independence in their professional role? If we are able to support and nurture the student in their development, then the process, rather than the product, must be the focus. This must have an impact on the quality of patient care in which the nurse meets the patient on their own terms, conditions and level (Nåden & Eriksson, 2002). My doubts and angst related to 'looking out' for the student are related to my potential to make the student dependent on me (as an educator) and deceiving them into thinking they're independent and assertive. Neville (2005) and Espeland & Shanta (2001) discuss issues of dependency and counter-transference between lecturer and student and I think it can potentially be a huge risk for both parties. I don't wish to conjure up an idea that I don't think students should fail or should at all costs reach the point of final registration if they don't have the capacity, but they should be supported to reach the point of decision-making and leave having learned something from the experience. In Annemieke's case it was, again, an eye-opener that she seemed able to place her nursing experience into



perspective and understand what she'd learned two years after having left the hospital, having had the opportunity to discuss the situations, in depth, that she'd experienced. I'm fully aware that normally, once leaving the programme, students disappear from sight and there is no system of follow-up – in fact, they may not feel the need for further contact, but this could potentially be a very damaging experience for an individual who is not able to move on or recognise they may need support in working through the things they've seen and experienced.

I'm not clear whether coping with situations that arise means that we have socialised into a system: namely, whether socialisation means that we've coped successfully, or whether coping is a temporary method of surviving, a way of 'conning' the environment into believing you've adapted/socialised, only to re-embrace your initial ideas and beliefs once you have the 'freedom' to set your own course. If the latter is true, it implies a system of power and (perceived) oppression. Somewhere deep inside, this is what I believe happens. I'm feeling a bit confused. Could learning to cope or, for that matter, socialisation not be seen as an educational process? Something we all have to learn in order to survive? Can the process of socialisation actually be separated from the individual's educational process? Bruner's (1996) work discusses the sociological/educational interaction in great detail. He suggests that 'education is not an island, but part of the continent of culture' (Bruner, 1996: 11). The interface between the two is clear: education has a role in the culture and the lives of those living in the culture. And, conversely, education 'reflects the distribution of power, status and other benefits'. Bruner argues that culture defines what is thought to be good and of value and, because individuals are part of that culture, they adapt to the demands placed on them by their environment. The insight I've gained through reading Bruner's work clarifies why some of the students – Olga, Lynda and Marijke – seemed to 'fit' into an educational framework, whereas Isa appeared to need first to rise above a sociological framework in order to learn and Annemieke seemed to fit more into the Parsonian sociological framework I chose, with learning from situations coming a lot later.

I find my thoughts returning to work by Carrithers (1992) which I previously referred to (pages 34 and 35), about socialisation and culturalisation. The way my participants tended to adapt to the different ward cultures and their understanding of the varying norms and values between the wards substantiate my previous argument that we need to speak of nursing culturalisation rather than socialisation. The decentralised interpretation of nursing philosophies means that different departments have the freedom to educate their staff according to their own needs and, listening to the students, there is a large discrepancy between the ward cultures. Take, for example, how one ward blindly follows



clinical pathways, whereas another is led by how the patient articulates their needs. This difference seems to be driven by the broader health care system, which again substantiates my previous suggestion that nursing is a culture within the ‘health-care society’ (page 39); a medically dominated society populated by medical, nursing and paramedical professions – each with their own cultures.

Until my transfer viva my approach to the research was neither sociological nor educational, but a hybrid of the two. Then, based on feedback from the viva, I felt I needed to make a decision and focused on an educational perspective as I’ve previously discussed. As I write my reflections on my process, my initial thoughts again move to a non-polarity between sociological and educational perspectives. To me, recognition of a sociological framework is a precondition to applying an educational framework – the two are complementary. I quote Bruner (1996: 14) on this issue as I feel excited to find what I thought was my intuition being contained in a seminal work, without knowing it at the time:

Nothing is ‘culture free’, but neither are individuals simply mirrors of their culture. It is the interaction between them that both gives a communal cast to individual thought and imposes a certain unpredictable richness on any culture’s way of life, thought, or feeling.

The **final aim I formulated for the study** was to

**explore the implications for the adult learner needing to learn to link theory and practice in a (semi-)employee role while dealing with the responsibility to care for vulnerable others and needing to learn from the experience.**

The stress students experience during a clinical placement is well known and apparent for all the obvious reasons relating to the new environment, new colleagues, new role, new skills and the pressure of assessment and so the focus on adapting to the situation could easily overshadow the learning component. I can identify with this. My want/need to be liked in a (new) work environment and feeling vulnerable and dependent on others to ‘learn the ropes’ of a new position, my need to understand the position of formal and informal leadership and the importance I attach to recognising manipulative politics within a group, makes me take on the role of peacemaker. As I reflect on my own experiences I have, in a new situation, not felt confident to challenge or ‘make waves’ until I’ve become more established and felt I had the status and earned the credibility from peers to voice my opinion. This pattern is mirrored in the students’ stories and, to my mind, has



less to do with issues of co-dependency and self-esteem as is sometimes suggested than it has to do with human nature. The role of peacemaker in a group can label someone as being a likeable person, but within the Parsonian model in which kinship, equilibrium and interdependence are important factors, an endangered equilibrium within the culture means disequilibrium of an individual's personal balance and so the person fights to regain their balance. The idea of adapting to a new setting, to me, is not therefore so much about altruism as it is about a personal agenda. The priority to create a situation of stability and perceived safety – kinship in terms of a Parsonian approach is, to my mind, an important precondition to being able to learn. Social consciousness, namely understanding how to behave/react in new culture, is important and first needs to be addressed before the individual is able to develop.

In Annemieke's case the value she gave to her life experience and her perception of justice made it impossible for her not to personalise the situation to the degree that she chose to distance herself from it. Annemieke's choice can be seen as a failure, but it can also be interpreted as an admirable strength. A difference between Annemieke and the other participants is that Annemieke has children and an established home life which caused tension between home and work – two Parsonian frameworks in conflict, one personal and the other professional. Annemieke's personal disequilibrium in bridging the distance between the two, seemingly opposing worlds resulted in her being unable to learn from the situation until she had removed herself and retreated to a safe distance. Her drawing intrigued me as the first and the sixth images in her drawing (page 174) are almost identical, only drawn with the sun shining from a different angle. My first response when seeing her drawing was that Annemieke had returned to where she'd started, and hadn't actually learned anything from what became apparent in our final interview – an emotional experience.

In our dialogue this was clearly not the case and Annemieke had gained a huge amount of personal insight from her nursing experience, which could explain why her sun was now illuminating her world from a different angle. Olga, Linda, Isa and Marijke all show movement in their drawings and highlight, perhaps, a different approach to learning from their experience and integrating their working and private lives. Life went on for them: a child was born, family members died and traumatic deaths were witnessed, some relationships slipped and broke down while other relationships were formed, there were times of ill-health and recuperation and priority, at times, was given to family ties – all this needed to find a place within individual lives. The equilibrium of the individual in terms of the Parsonian model is paramount to creating balance in order to learn from the situations they experience.



Common to all the participants (not excluding myself) is the necessity and importance of social interaction in order to construct social reality and develop common sense to deal with situations as they arise. Cultural knowledge and clues are taken from social context, and learning can occur only through an interaction of the individual with the environment (Knowles, 1980; Kolb, 1984; MacIntosh, 2003). All the participants spoke in some way or another about ‘just knowing’ when dealing with patients or staff on the wards. The idea of ‘just knowing’ resonated with work by Neville (2005) and Leners (1992) in which they discuss elements of intuition. But there was more behind integrating theory and practice than intuition, although it did seem to stand the students in good stead when dealing with issues of power on the wards; as Annemieke mentioned, the registered staff ‘just radiate’ authority (05-A34.25). I didn’t pursue this point of discussion at the time but, in hindsight, I could have discussed Annemieke’s perceptions of ‘authority’ versus ‘power’. But equally I’m aware that this dichotomy has a lot to do with me and my entanglement of the two. The examples of my silence when witnessing bullying illustrate the way in which I allow the power I assign others to cloud my judgement and not acknowledge the authority I see in the individual being bullied. Neither do I acknowledge my own authority in the situation. I try to be invisible.

I recall, with some pain, a team-building day in which we were requested to illustrate where we were in relation to the team ...



*Philip's barren earth vigilante*



I saw myself in brilliant, but blinding sunshine attempting to negotiate a barren expanse populated only by stones which provided no shelter, but also hid dangers. I was exposed to threats from above and below. I could see the hill where I was heading as being fertile and lush, but I needed to cross the barren earth in order to get there. Although I couldn't see the other side of the hill (and it was in shadow), I knew it was also lush and fertile.

I felt we needed to 'look out for one another', hence the meerkats.<sup>14</sup> I found it hurtful and angering, but insightful, to realise that the situation of bullying I'd witnessed had penetrated far deeper than I could have imagined at the time. A second confrontation for me was when we shared our drawings with one another – everyone else in the team had used bold felt-tipped markers, whereas I had used coloured pencils ... the only thing visible from the centre of the floor where my drawing lay was the postcard of the meerkats – everything else was vague and indiscernible ... I was hiding and trying to make myself invisible to the team.

My feelings of vulnerability during this team meeting were reawakened by Annemieke when she 'gave' me the responsibility to 'look out' for the students coming through the system – I would have to be more visible ... but I still feel that I can't 'protect' others from what they need to experience and learn.

I may be trying to alleviate some of the pain in the situation but there could, after some reflection, be another interpretation to my drawing – one that symbolises transparency and unpretentiousness. I recognise that part of myself too. Although quite competitive in some fields, I don't feel the need to push myself forward if I have the feeling others are vying for a position of favour or authority. I tend just to get on and do what I need to do – the acknowledgement comes if and when it is meant to come.

I don't feel I should separate elements of the student's integrated process of learning on the ward.

All the students, motivated by perceptions of a calling or predestination, focused on learning as much as they could from their experience and, based on our final interview and their drawings, had reached a place that they were satisfied with by the end of the programme. All of them articulated that the experience had provided an extra dimension and meaning to life.

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<sup>14</sup> 'Meerkat' is South African English for a member of the suricate or mongoose families.



Reaching the end-point of the programme sometimes meant challenging colleagues and the status quo of a team even though they felt intimidated by the knowledge and experience of others. One student spoke of the importance of learning the theory behind communication techniques and her application of these principles to communication at work and in her personal life.

The students, however, felt that communication was not always possible on some wards and opted for survival rather than confrontation, which had little to do with their assertiveness. These more ‘negative’ experiences meant that they wanted to make a well-considered choice of ward to work after graduation – it was important that the ward they chose would allow them to find their own space and confidence. During the course of the programme all the students moved away from being subordinate and needing to please to being assertive; and all of them described a turning point at which they took control of the situation.

All the students shared how important they found reflection to be. They all seemed to think that small group or individual supervisory meetings created a situation from which to learn. I am excited that these students feel they have benefited from reflection as I have always supported the idea that self-awareness through reflection is the way forward to improve patient care. My assumption was that self-awareness could lead to empowerment and emancipation. This calls for a moment of reflection ... Possibly because in my role as a researcher I was more open to learning and interaction than I had been as an educator. Or possibly because I had the space and protected time to focus on each student individually; whatever the underlying reason, the students in my study taught me a huge amount. But the idea of learning from reflection goes further. Bruner (1996: 19) suggests that:

‘thinking about thinking’ has to be a principal ingredient of any empowering practice of education.

This has certainly been true for me ...

### **Reflections on the study**

I still have an issue with the idea of a deviant case study, however. Another opt-out perhaps, but I like Muncey’s (2002: 177) suggestion:



Perhaps there are no deviant cases, perhaps there are just lots more individual stories waiting to be told, stories that are sometimes difficult to tell, that need support and understanding in the telling.

I don't feel comfortable in presenting one of my participants as a 'deviant case'. Within the context of my study this would be Annemieke as she did not complete the programme ... but I don't find her 'deviant'. The terminology is resonating too loudly at a personal level and conjuring up images of the stereotyping I've needed to deal with in my life.

I find this an interesting point to reflect on at a different level – the fact that I chose the highly structured Parsonian model of society in which everything has a place. I have moved on from here. Things have become more fluid and organic – nothing is really as it was. Deviancy can be deviant only if there are strict rules stipulating what is and isn't. As the rules providing structure have become less important, so I've felt more and more uncomfortable with the terminology of a 'deviant case'. I see how I have changed in the way my original theoretical frameworks have become more restrictive as my research approach has become more fluid and my methodology more organic to suit the research as it evolved.

In terms of predestination, I've needed to travel this route with committed souls to reach the point of sharing my own story in the context of my being a nurse, researcher and an educator. In contrast to where I originally started, my research is not solely about the students, but it is also about me. I've needed to engage in this process to reach a point at which I'm able to challenge peers and colleagues in a way that could lead to a change in the status quo. I have been silent too long. In my perception I may, in some way, be breaking down the ivory tower of education and academia ... this could be my feeling of vulnerability ... authority has, after all, been an issue for me ... I am convinced that my anxiety of showing vulnerability through my thesis is comparable to the student's vulnerability at giving feedback to their mentors. It makes me think again that we're all on the same route, only at different places, and that we all have something to learn from each other.

I certainly learned a huge amount from my dialogue with the students. The five out of the nine participants who have stayed the course suggests a certain mentality of choosing to be part of an ongoing study and being willing to learn from it, in just the same way that I have chosen this research approach ... or perhaps it chose me because that's where I am at the moment?



During the interviews I became acutely aware of how easy it was to pick up on a facet of a story that I thought was important and how obligingly the students would talk about it and reflect *ad infinitum* on what it meant to them. Important though it was, it was sobering when Olga told me of how the one story I kept returning to was just one of many and just one, at random, she chose to share with me. And so each of the students provided me in some way with insight into who I was as an educator. How judgemental I had initially been of Annemieke when she dropped out of the programme or of Isa who seemed to fit my stereotypical image of a surgical nurse and how both of them – possibly without being conscious of it – had allowed me to see and understand what I was. I marvelled at Marijke's development into an assertive and articulate woman and her courage to keep striving to achieve her goal against the odds of orthopaedic surgery. And Linda, who showed me how to deal with personal setbacks and use them to grow from strength to strength *and* maintain an incredible sense of humour.

Each has mirrored aspects of me as an educator I wasn't fully aware of – I feel truly humbled and incredibly privileged. I'm also aware of the pain of letting go and moving on ... I hadn't imagined I would feel what I do. I'm only now closing the door on a very happy chapter of my life spent in an inner-city hospital in The Netherlands, but I think this has to do with realising that we'll all move on in our own directions ... the realisation that we all just pass on the path of life, but sometimes we have the pleasure, and sometimes the pain, of sharing a section of that path with special people and become inspired before moving on at our own pace.

What is this feeling of vulnerability? Am I about to be unmasked as a fraud? Am I running the risk of being exposed to peers and students who now (still) respect me – does this mean that I don't feel that one can be respected if one is vulnerable or does this give one the strength to rise above issues that would otherwise hold one back? I think this is a challenge to me and to others in education to come out and identify their frustrations, their own agendas and motivations – I feel this is necessary if we are to follow a student-centred approach to education.

Looking back, I do not feel – even with the new insights I have – that I was victimised during my education. Sometimes there were difficult situations, but I grew from the experience. I think there is more chance of victimisation after graduation when we start cycling without the side wheels of student status to support us – this could explain the attitude of registered staff in striving for supremacy and power (Freshwater, 2000b; Farrell, 2001; Hutchinson et al., 2006).



Pausing for the umpteenth time – the idea of being one of the many ‘individual stories waiting to be told’ is starting to resonate with me – I recognise the feeling of being called, the idea of predestination and the thought of being an incarnation of Nightingale ... and I still have the dream that I strive to mean something to students and those I teach and, therefore, indirectly mean something to patients. The Jean Brodie in me flickers into life: ‘You girls are my vocation.’

But this calling has its dark side – the dysfunctionality and sometimes misguided focus of Brodie’s role and her reliving her life through her students. What does that say about me? Am I misguided by trying to emancipate those already emancipated or am I being singularly paternalistic to assume that students/women want/need emancipating or empowering (by a man)? I suppose the answer is both yes and no ... No, I don’t think I am misguided (I’m struggling to put this into writing and afraid to be thought of as arrogant – it is interesting that I’m not able to just accept positive feedback) – I have often been given feedback that I provide personalised contact and am considered to be inspirational. And, yes, I’m critical of the system but I don’t think I’m paternalistic – I think a lot needs to be done in the area of emancipation and empowerment, but each person needs to live their own life and grow from the experience.

From a researcher’s perspective, my tendency to sometimes over-identify with the students initiates a discussion regarding the validity of my study. McCorkel & Myers (2003) discuss this issue and highlight the criticism of ethnographic research with regard to meeting standards of objectivity and reflexivity. I have attempted to address these issues by providing insight into my own issues, in relation to the participants’ stories. I have been reflective and reflexive in how I interact with the students; I have articulated my awareness of power balances; I have discussed my previous and current position and role in relation to the students and the organisation and have adapted my behaviour and attitude accordingly. I think that by providing this degree of transparency it allows the reader to distil, to some degree, what my issues are and what are the student’s; but also I hope that the conflict and contradiction this symbolises stimulates the reader of my work to reflect on their own position. As previously discussed, my educational process is linked inextricably to my personal and professional cultural and sociological backgrounds, but it is simultaneously linked to the reader in the same way. As I have needed to confront my over-identification with the participants, so the reader is challenged to confront theirs.

I feel that I’ve become aware that the crux of my socialisation was not via nursing into the secretive and victimised world of the mystical woman of long ago, but via my mother into a tangible, feminine world. This could be the root of my striving to emancipate and



empower; this and my personal crusade as a gay man will definitely have formed my ideas of emancipation and empowerment and how I view the traditional role of the woman. I don't, therefore, think that the dynamics of power and resistance among nurses on the ward are any different from those among staff in academia or a commercial organisation (Falk Rafael, 1996; Buckenham, 1998; Einarsen, 1999; Farrell, 2001; Hughes, 2001; Bryant & Wolfram Cox, 2003; Degeling & Carr, 2004; Hutchinson et al., 2006). Where does this leave the negativity of the nursing publications? Are they tapping in to a group who are sensitive to oppression and co-dependency through the ascetic nature of the work? Or is the nursing world simply a mirror of the society we live in, only more focused and, therefore, more magnified?

My process through this research has been one of combining and interrelating education, research and practice. I have not been able to distil one from the other and one aspect of my work has fed and inspired another. Understanding and exploring aspects of my own socialisation have provided me with insight as to my decisions and motivations and has helped me focus my identity as a researcher and an educator. I find I am not able to provide a teaching session or conduct supervision without being aware of issues related to socialisation, but I've had that for a long time. What is new to me is an awareness of personal issues that may surface and the way I now consciously deal with them – either by acknowledging them to myself and keeping them outside the dialogue, or by introducing them into the discussion, if appropriate, and discussing them openly in terms of my input. For me, new behaviour surfaced recently when I withdrew from facilitating a series of workshops as I felt that I was being drawn into an agenda that wasn't being articulated and would not be acknowledged by the group. Previously I would have remained in the situation and tried everything I could to protect and rescue the situation; now I felt that my only responsibility (to the group and to myself) was that I didn't take the full responsibility, but left the group's responsibility, as it should be, with its members.

There have been definite parallels between the students' and my experiences. The feelings of vulnerability and insecurity and the way the students used their known experience as a base from which to learn new knowledge and give them confidence – more than once they articulated how overwhelming they found it when confronted with too many things. I experienced a similar situation in attempting to use my research experience from my Master's degree for my doctoral study. To some degree this worked, but largely it didn't – it was a steep learning curve to be comfortable and accept that things were where they needed to be.



Another new experience was my overwhelming feeling of responsibility to the students to represent the things they had told me as accurately as I had understood them to be. At times this had quite a paralysing effect on me and I was afraid to work with their interviews for fear of compromising their input. My responsibility to be accurate, although important to the quality of my research, had more to do with the moral obligation I felt towards those who have shared their stories with me throughout the intervening years. My responsibility to be ‘true’ to the stories that had been shared with me has, undoubtedly, a lot to do with my upbringing. I remember once reading sections of Aristotle’s *The Nicomachean Ethics* (1996: 103) some years back in which truthfulness, in the ideal world, was habitual; and further refers to the pinnacle of ‘moral excellence’ when an individual avoids untruth for its own sake, and especially does so when it ‘is morally base’. To consciously misinterpret the stories shared with me would, for me, be unforgivable and ‘morally base’. Aristotle’s writings go on to say that an understatement is preferable to exaggeration ‘since this appears in better taste, as all excess is offensive’. This philosophy is key to me and probably underpins my hesitance to take centre stage, as I have discussed previously.

My choice of theoretical frameworks provided an interesting slant and an acceptable place to start from, and all three provided a way of viewing the data – without this structure, the volume of data would have been unmanageable and overwhelming. The Parsonian framework (Fulcher & Scott, 2003) was simplistic but broad and practical, allowing me to illustrate the dynamics of the nursing culture as I understand it to be. In retrospect, I found the DeMeulle & D’Emidio-Caston model (2003) quite restrictive as it tended to fragment the process of analysing the data. It’s unfortunate that the authors were not prepared to discuss with me the empirical underpinnings as it may have assisted my application of the data. Nevertheless, it has provided some degree of clarity as to how the interplay between the four domains allows integration and has provided me with insight as to which areas presented barriers to their learning. I feel their model complemented the confluent education model put forward by Castillo (1974).

I am challenged to choose ‘one nugget’ of new knowledge from this journey.

From a sociological perspective, the students participating in my study are not self-sacrificial, mindless beings *adapting in order to fit in* – I’ve seen another side. They are intelligent women, making proactive choices of how to best deal with the challenges *they* face and make specific decisions to reach the goal they see before them.



From an educational perspective, facilitated reflection is immeasurably valuable, but ... the role, input, background and history of the facilitator are vital. If the facilitator is insufficiently conscious of what is driving them as a nurse and an educator, this can alter the tool of guided reflection from being one of emancipation and empowerment to being an instrument of destruction and oppression.

### **A final word**

I've been as true to Olga, Isa, Linda, Marijke and Annemieke as I know how and have sought to let them provide their own explanations. Any attempt at summarising the interviews to bullet-points would decontextualise the content and reduce it to words rather than allowing it to retain its own meaning and tell the individual stories

This has been a remarkable journey and I have been privileged to walk part of my path with five remarkable women.

Peter has been silenced and I have found my voice, I am visible.

The boy stood up shakily, and looked once more at the Pyramids. They seemed to laugh at him, and he laughed back, his heart was bursting with joy.

Because now he knew where his treasure was. (Coelho, 2006: 155)



## Epilogue

At the end of this particular journey it's appropriate to reflect on the process after having distanced myself from it to some degree. In some ways I find this reflection difficult as my thesis is bound together by reflections on my process and insights into my reflexivity at the time. This is the transparency I have attempted to provide throughout my doctoral journey. I have already moved on from where I was at the point of submitting my work so, by definition, my views and ideas will be different to when I close off the project. My reflections at this point are relative and will have altered again by the time I submit the final product. This makes me aware of the timeless, endless process of learning through reflection.

What I am about to do is to reflect on a couple of essential issues. How does my work differ from that done by Melia (1987) and Spouse (2003), both of whom researched the socialisation process of student nurses? And what, after some distancing on my part, do I consider to be the benefit of my five-year process?

So what is the difference between my research and the seminal work undertaken by Melia (1987) and Spouse (2003)?

The research population is different. Melia's (1987) student population was drawn from nursing colleges and the students were part of an apprenticeship model of nurse education used at the time. Spouse (2003), on the other hand, researched students registered in a full-time higher education nursing programme in which students had short placements in different departments. The students involved in my research were participating in a differently constructed programme in which, although registered in a degree programme, they were situated primarily in practice.

In addition, the students participating in my research were Dutch, undertaking the nursing programme within a Dutch context. Although there are similarities with the students participating in Melia and Spouse's research there is a cultural difference due to the historical and professional background of nursing in non-Anglo-Saxon countries when compared to nursing history and development in England, Australia and the United States of America where most publications on this topic originate. In The Netherlands, nursing has a less traditional image than in Anglo-Saxon countries.

I feel that the difference in the perceived hierarchy within the cultures is influential and, therefore, impacts on the role of a nursing student. In The Netherlands nurses wear no insignia or uniform to indicate rank seniority. Originally, nursing students and registered



nurses were expected to wear a pin indicating rank or registration with the national regulating body but, in practice, this seldom occurred and is now voluntary. The fact that Dutch nurses chose not to wear the specified insignia (however small) indicates a cultural response to authority and, consequently, influences the way the participants of my study communicated and negotiated with the ward staff.

In essence, the Dutch students' perceptions of authority differ subtly from their English-speaking counterparts: they recognise power relationships – although these are generally more informal, rather than the traditional, established order found, for example, in England. They negotiate survival strategies, although it became apparent that they are not passive partners in their socialisation process but use conscious strategies to 'survive' some practice placements. And they have clear ideas regarding the quality they observe in practice and are critical and normative as to the examples of care provision and team leadership.

Another difference between Melia and Spouse's work, I think, is that it is influential that the students participating in my study are mature students who bring more life experience to their study than school leavers. I realise that my research could have been quite different had my participants been younger and less experienced in life. Spouse (2003) indicates using 'mature students' with 26 and 27 years of age being the oldest, whereas my participants' ages varied from late twenties to above 40.

I also think that my role as researcher in relation to the students is important. As I had left the country and had no status to influence their programme or progression I see this as being very different to either having peripheral contact with them, or even being based within the same organisation. This is an issue that both Melia (1987) and Spouse (2003) discuss. Melia (1987: 195) mentions that, at times, students would share experiences accompanied by remarks such as 'I shouldn't really say this...' and Spouse (2003: 21) indicates that '...students may have believed that I could influence their course in some way and may have slanted their conversations.' Neither of these situations arose, or was in any way discussed, during any of the interviews I had during the five years of my study which indicates to me a less guarded, equitable relationship between the participants in my study and myself as a researcher.

By placing the case studies of my participants within the context of my own story allows an interactive and collaborative research process to evolve. I do not try to objectify the students' experiences. Neither do I attempt to classify or categorise their journeys. I have tried to stay as close to the individual student's journey as I possibly could which provides insight into how they developed and made sense of their experiences – the essence of my chosen, ethnomethodological, approach. This has also resulted in a new



insight as to how I (as a researcher, educator and nurse) have been affected by the things I've heard and how I've attempted to make sense of them. I have shown the transparency of my process as a researcher.

A strong element of my research and subsequent thesis is the insight I've gained as to my own processes as a researcher, educator and nurse. I have found this a very powerful and, at times, confronting experience which I share with the reader. As such, I attempt to engage the reader in reflecting on their own experiences and who they are in their professional role. This is another reason that I've chosen not to provide a model based on my findings – not only do I find it inappropriate to suggest an excess of knowledge in the form of a theoretical model based on the experiences of five students, but it has also never been my intention to prescribe or steer the reader in any particular direction. Possibly most important is that I don't want to superimpose previous frameworks with yet another structure. This would, to my way of thinking, detract from the intention of my study which I see as being experiential for the reader, rather than prescriptive. I see my, perhaps unconventional, thesis presentation as an aspect of the methodology in its own right.

A new dimension resulting from my research is Annemieke's participation. Some of the participants in Spouse's (2003) work also stopped with the nursing programme, but recommenced at a later date and ultimately graduated as nurses. Annemieke was different as she didn't re-commence her nursing studies. This is another difference between my work and the research done by Melia and Spouse – their work focuses on the students who adapt (or return) and stay. The findings imply a linear adaptation/socialisation in dealing with peer pressure and coercion, which are represented as themes and categories - the choice and construction of the researcher. Whereas in my thesis I highlight the 'deviant case study' or, perhaps more positively expressed, the individuality of all students. Each student is led by their personal history, goals and ambitions and, therefore, has an individual story to tell which is not always appropriate to represent within a generalised model. I feel that if I had to structure my findings in a categorised format suggesting some form of generalisation, I would detract from the individual's story.

Rather than polarise my research with work previously done by colleagues, I tend to view differences between the studies within a time and environmental perspective. My doctoral research experience has been characterised by influences resulting from supervision and the creative workshops I participated in. I took part in many debates critiquing the dominant, often positivist-slanted, discourse which directs health care and academia but I am not in a position to debate possible environmental or philosophical influences which may have directed other authors and their previous research. I don't think that a



hypothetical discussion is important or beneficial unless the dialogue includes the authors themselves – I feel that each new piece of work should have its own merit and the resulting discussion adds to our communal insight and body of knowledge. Dialogue is, in that respect, valuable and beneficial.

The work by Melia and Spouse has, in many ways, been inspirational to me but, as I've already mentioned, what I didn't want to do was to suggest another theoretical framework. I respect their work for what it is and feel that I have built on the existing knowledge base.

What do I consider to be the benefit of my five-year process?

Important has been Annemieke's agreement to remain part of the study and her participation provides new insight into the perceptions and experiences of 'the one that got away' and, at the same time, contextualises the stories of the other students. By sharing her story, she provides a greater understanding of the retrospective emotionality of being a student and the impact situations can have. She uncovered, to some degree, how she made sense of reality and her coping mechanisms are aspects of these students we don't normally see. This is new knowledge as we've not known how students respond after leaving a course but, conversely, the research has also highlighted the way students are exposed to one situation after another, in quick succession. It is often a *conscious choice that sometimes they simply leave situations be*, without addressing them or investing energy to resolve them. They make active choices of *what to address in a reflective session or critical incident report*, and select how much detail and which elements to discuss – in other words they provide a selected personal narrative of their preferred story.

It is more than likely certain that another researcher will have asked the participants different questions. Even if another researcher had, in essence, posed the same questions they would have been formulated differently because they would be framed by the researcher's specific life story and experience. This would, most likely, have resulted in a different nuance in the student's response. The interaction, and therefore the answers, would also be dependent on the relationship between the researcher and the participant. Taking these aspects of dynamic interaction into account, it's safe to say that this type of research can never be accurately repeated which means that all insights resulting from this form of research contribute to the existing body of knowledge. Even if the reader disagrees with some of the findings and challenges the author's decisions, it is not always what has been SAID, but equally what remains UNSAID on the part of the author – and the reader - that affects new knowledge – in this case the reflections and reflexivity of



both parties. This interpretation on the part of the reader influences how knowledge develops as it is the personal interpretation of the knowledge base that colours future research in an area.

I ask myself who owns this research. Because of the interactive nature of the work, I see this form of research as being collaborative. There is self-reflection by all parties – participant, reader and researcher. It is human that there is the risk of projection and counter-transference between the parties which is why it's important that the researcher/author be clear as to their position so that the reader has sufficient information to decide what and where 'truth' is.

As researcher I've tried as fully as possible to showcase 'my truth', but I'm aware that it's impossible to provide a story that is a hundred percent complete – consciously or sub-consciously I indicate what 'truth' is to me. The reader does the same from their perspective and within the framework of their life experience but is, simultaneously, selective and led by the context of (a) the research and (b) his/her life story and experience.

Another question raised is whether the case studies have been instrumental for my self-exploration. This has been the catharsis of my process. I had not realised that it would happen when I started out on my research path, but it has been part of an evolution. Retrospectively it's been a transformative process for me (as person, researcher, nurse and educationalist), but also for the students, each of whom indicated in their own way what the (positive) experience had meant to them. This is the essence of what I mean when I speak of collaborative research. The participants were not passive partners in the process from whom I (the researcher) plucked information and then interpreted as I saw fit, but they were as much part of a transformative process as I was. This had to do with the reflective questions I posed them on which they reflected differently (some would say more deeply) than when they worked through the same situations using a critical incident format and remaining descriptive.

In discussing the research aims in Section 10 and based on the educational questioning that I used (table 3.1), I have used the answers I received from the students. I'm aware that the results will have been different if I had used a sociological approach.

I address the research aims within the paradigm of an ethnomethodological approach. Namely I provide insight into the individual's understanding and explanation of how, within the context of their personal life and experience, they make sense of their experiences within the framework of the educational programme they are engaged in and



the reality of daily work in various nursing departments. Within the context of their experience I suggest how I have seen their educational and professional development. In my study each of the students embarked on their journeys into nursing with an existing philosophy of care which coloured their expectations of the programme and their future as nurses. In the course of their journeys they all articulated how they had remained true to their initial philosophy of care, but that they felt in some way predestined to do what they were doing. My interpretation of this progressive enlightenment or awareness is the embodiment of the work by Maslow (Boeree, 2006) on self-actualisation and Knowles (1980) on dimensions of maturation – key elements of adult learners. This transformational process as described by each of the participants in turn answers all the research aims I set in one swoop – another indication of how I, initially, was seemingly confined by wanting to deconstruct and theorise what, retrospectively, I should have recognised as being a holistic process. It is within this paradigm of my assumptions that I address the aims of my study and why, when discussing each aim, I provide the reader with a personal context.

I don't believe that the strength of this type of research lies in facts and figures being served ready for consumption (our expectation of being served research findings in this way is, in itself, a symptom of our socialisation into a positivist society), but the strength lies in providing the reader with stimulation to reflect on his/her experiences and, as a result, to be reflexive and move forward from the experience of being exposed to the research with new insights and, perhaps, modified behaviour.

Each person has their own story and sometimes there is an overlap, but at other times there seems to be none whatsoever. By providing transparency I provide the reader with as much clarity as I can as to how I interpret and use my reality as a researcher, nurse and educationalist. And these are, once again, points of reflection and reflexivity for the reader. The strongest theme throughout my thesis and the link in my referring to the book *The Alchemist* (Coelho, 2006) is that we – participant/student, researcher/author and reader/practitioner - all need to traverse a reflective process before coming, full circle, to understand what our personal 'truth' is.



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## **Appendices**



**Appendix 1: Overview of clinical placements of study participants**

To protect the privacy of the wards the names have been coded using letters of the alphabet and indicating whether they are surgical or medical (non-surgical) specialisations.

**Surgical wards:**

cardio-thoracic surgery, general surgery, gynaecology/urology, orthopaedics, vascular surgery

**Medical wards:**

oncology/haematology, neurology, cardiology, pulmonology, nephrology/gastroenterology, general medicine/HIV Aids

<i>Year 1</i> <i>Fragmented placements</i>	<i>Year 2</i>	<i>Year 2</i>	<i>Year 2</i> <i>Mental health placement</i>	<i>Year 3</i>	<i>Year 3</i>	<i>Year 4</i>	<i>Year 4</i>	
						<i>Differentiation of choice</i>		
<b>Olga</b>	Ward A medical	Ward B surgical	Ward C medical	Chronic mental health – independen t living group	Ward D surgical	Maternity leave & Ward D surgical	Ward A medical	Ward A medical
<b>Linda</b>	Ward C medical	Ward E surgical	Ward F medical	Psycho- geriatric/ Korsakov	Ward G surgical	Ward H medical	Ward I medical	Ward I medical
<b>Marijke</b>	Ward G surgical	Ward H medical	Ward J surgical	Acute mental health – Scotland	Ward C medical	Ward I medical	Ward K medical	Ward K medical
<b>Isa</b>	Ward F medical	Ward D surgical	Ward C medical	Mental Health Rehab. – independen t living group	Ward E surgical	Ward A medical	Ward K medical	Ward K medical
<b>Annemieke</b>	Ward H medical	Ward J surgical	End prog. 9 January 2004	X	X	X	X	X



**Appendix 2: Overview of interviews with participants**

	<i>Group session with full cohort during orientation</i>	<i>Focus group – official start of data collection for research project</i>	<i>Individual interview</i>	<i>Individual interview</i>	<i>Individual interview</i>	<i>Individual interview</i>	<i>Individual interview and symbolic drawing</i>
<b>Olga</b>	X	December 2003	June 2004	X	April 2005	January 2006	June 2006
<b>Linda</b>	September 2002	December 2003	June 2004	November 2004	X	December 2005	June 2006
<b>Marijke</b>	September 2002	December 2003	June 2004	X	November 2004	December 2005	June 2006
<b>Isa</b>	September 2002	December 2003	June 2004	December 2004	X	December 2005	June 2006
<b>Annemieke</b>	September 2002	December 2003	X	December 2004	X	December 2005	June 2006