**Student nurses' perceptions of patient/client care:
a qualitative analysis**

Dorothy Horsburgh

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I certify that this thesis has been written by me
and is my own work.

Dorothy Horsburgh

ABSTRACT

This thesis explores the perceptions of students undertaking a Diploma of Higher Education in Nursing, in relation to the care practices that they encounter during their practice placement allocations. Specifically, the factors and processes, by means of which students deem the quality of care provision to be satisfactory, or otherwise, are analysed. A central concern in the thesis is identification and exploration of the changes and constancies in the students' perceptions over time.

There is little published work addressing the above issues and a qualitative, grounded theory approach has been adopted, the data being collected by means of in-depth interviews with a small number of student volunteers. A total of thirty interviews took place, the majority of participants being interviewed on four occasions during their three year programme. The data were concomitantly collected, compared with other data, analysed and coded throughout the study.

Findings indicate that the students' conception of care, as related to nursing work, contains some important variations from the concept as used by policy-makers in nursing. In relation to their moral reasoning, the students' accounts indicate processes that are more subtle and complex than some of the influential theorists (Kohlberg, Gilligan) suggest. Students do not appear to adopt a perspective based on justice or care *per se*, although elements of these principles are present within their accounts. Rather, the students' moral reasoning processes become increasingly focused, over time, upon *providing care in context* and this emerges as the core category, and basic social process, within the study. The students, in progression through their programme, gain access over time to a 'wider picture' than is available to them during their initial practice placements. Increased experience and concomitant acquisition of confidence enable students to place the provision of patient/client care in the context of the substantive circumstances pertaining to the individual. Development of the ability to view care *in context* appears to be accompanied by a reduction in reliance upon *abstract* moral principles as a guide to behaviour. Direct involvement in patient/client care and the ability to access the 'wider picture' increases the moral complexity of decision-making for students. This is viewed by the students as being a prerequisite for good nursing practice. The factors which facilitate and inhibit provision of care in context are discussed and some implications of the study's findings for nurse educators and service providers are suggested.

ACKNOWLEDGEMENTS

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Chapter One

Introduction to the study

Introduction

The aim of this thesis is to explore the perceptions of student nurses, in relation to the patient/client care that they encountered during their practice placement allocations. More specifically, its purpose is to identify and discuss the factors and processes, by means of which students deem the quality of care to be satisfactory, or otherwise. There is a scarcity of published work addressing student nurses'*own* perceptions of care and this appears to constitute a significant knowledge-gap, given that today's students are the qualified practitioners of the future, whose practice will be influential in care provision. An exploration of the students' perspective and of the changes and constancies in their perceptions over time has then relevance for both education and practice.

Health and social care provision is frequently at the forefront of media discussion and debate within the UK, precedence being given to issues involving life-and-death decision-making, resource-allocation, the length of waiting-lists and practitioner malpractice. Demographic changes, and the implications of these for providers and recipients of nursing and social care provision, have received increasing attention in recent years, as has the re-location of care from institutional to community settings, although discussion of the latter frequently focuses upon a perceived threat to public safety.

Given that health and social care are required by all individuals, to a varying extent, at some point during their lives, this exposure to public interest and scrutiny is unsurprising, as the potential, and actual, relevance of the topic can be clearly envisaged by all members of society, as well as being subject to their direct experience. The preparation for practice of those involved in care delivery is then of interest in relation to the perceived strengths and weaknesses of educational programmes in ensuring the competence of qualified practitioners. There appears to be little interest, however, in exploring health care practitioners' own perceptions of their occupation.

The nature of health and social care provision is such that decisions made and the treatment and care provided, or withheld, may alter the duration and quality of the lives of the individuals who experience it. The perceptions that student nurses hold in relation to their intended occupation are likely to have been shaped, in advance of their own selection of nursing as a career, by society's representations of health and social care. These depictions, coupled with the student's own experiences and consequent interpretations, are likely to provide the yardstick against which they measure their own preparation for practice. Occupational socialisation, within both academic and practice placement settings, is influential, as is direct experience of care provision. This influence is iterative, for not only will the care provision that the students witness affect their perceptions and behaviours, these perceptions and behaviours will then impact upon the quantity and quality of care provision that the students provide during their preparation for practice. This, in turn, will influence their subsequent practice as registered practitioners. An inquiry into the perceptions held by student nurses in relation to nursing work and the delivery of care is, then, of interest not only to researchers and nurse educators, but to any and all who have responsibility for care delivery, or who are its potential or actual recipients.

'Moral Worlds'

Shotter (1984) writes that:

> Our accounts of ourselves must clearly be situated in the world to which we owe our being as we understand it, in the world of our everyday social life...issues of selfhood and social accountability are inseparable: one cannot become the kind of person required in one's society, ie one able to reproduce its social order in one's actions, unless one learns its accounting practices, the authoritative ways of making sense...
> (Shotter 1984:pp x-xi)

Shotter (1984:p143) argues that humans create and sustain, by means of the collaborative action which is a prerequisite for societal functioning, a 'moral world', which is seemingly 'external', but within which individuals are able to provide explanations for their behaviour which will be comprehensible to others. Shotter (1984:p150) states further that, "The 'moral world' so produced contains within it, implicitly, a view of what people in it *ought* to be like."

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Silverman (1993:p82) writes, in a similar vein, that the way in which we define an activity is morally constitutive of it: thus 'good' or 'bad' are moral value judgements. He argues that:

> ...By analysing how people talk to one another, one is directly gaining access to a cultural universe and its content of moral assumptions. (Silverman 1993:p108)

Thompson et al (2000:p258) argue that, "...moral judgement, decision and action are as natural a part of living and doing as breathing. We all grow up in some sort of moral community." They stress that not all moral decision-making is associated with drama and crisis and that, "...most of us develop remarkable skill in making rapid moral assessments of the problems facing us in the practical situations in our lives and in taking the appropriate decisions" (p256).

Downie and Calman (1993) state that:

> ...*morality is inescapable*. The point is that living together with other people requires that we acknowledge certain actions to be right or just or compassionate, and others to be wrong or unjust or inconsiderate. Without some agreement on what we ought to do, and what we must not do, there could be no social harmony and co-operation...we may not be conscious of the moral nature of our actions precisely because morality is an inescapable part of our lives...
> (Downie and Calman 1993:pp15-16)

It may thus be argued that morality, with the concomitant requirement for the processes of moral reasoning and the making of moral judgements, does not comprise *one* dimension of life within society but is integral to, and indeed a prerequisite for, its functioning.

Nursing as a moral enterprise

Downie and Calman (1994) use the terms 'morality' and 'moral decision', rather than 'ethics' and 'ethical decision' to refer to the practical problems encountered by all individuals. The state that their reason for doing this is two-fold:

> [firstly]...it brings out the *continuity* between the moral problems of everyday life and those encountered in hospitals or other spheres of professional practice...[and, secondly]...the terms 'ethics' encourages a

narrow view of morality as consisting simply of the 'do's' and 'don'ts' in a code. In our view morality must be seen *broadly* as including the whole area of value judgements about good and harm...It is because many health care professions take ethics or morality in the narrow sense that they are unaware of the extent to which they are continually making moral or value judgements in the broad sense.
(Downie and Calman 1994:pp5-6)

They emphasise this further by stating that:

[Morality]...is a pervasive concern, affects all our activities and carries commitment with it...it is misleading to think that there are clinical discussions or professional decisions and occasionally also separate moral decisions. Rather, our argument will be that *all* clinical or professional decisions have a moral dimension to them, for morality, like attitudes, is all-pervasive. Moreover, since morality is all-pervasive it cannot be compartmentalised and it is therefore impossible to separate the moral decisions of someone in a professional capacity or role from the moral decisions of that same individual in a private capacity.
(Downie and Calman 1993:p12)

Thompson et al (2000:p10) similarly argue that moral choice is an integral, and inescapable, part of everyday life. A focus upon life and death dilemmas clouds the fact that the majority of moral issues faced by nurses are encountered in daily practice.

...the whole question of our health - as individuals, in family life, in our work and in society - is not a matter of indifference to us...'health' and 'disease' are normative terms, ie they describe the state of an organism as approaching ideal or optimum functioning or varying degrees of malfunctioning or dysfunction.
(Thompson et al 2000:pp 103-4)

Within this thesis I shall support the view of Downie and Calman (1994) and Thompson et al (2000) that the relationship of nursing to health and wellbeing renders it a moral enterprise and that it is thus impossible to identify some elements of its practice as morally-significant and others as morally-neutral. *All* decisions and actions taken (or omitted) in relation to client care are irrevocably connected to their beneficial, or harmful, effects upon the client.

Background to the study

My interest in the exploration of the experience of student nurses originated in part from studying the influential theories of Kohlberg and Gilligan and the volume of work generated by their approaches to moral reasoning and moral judgement. There did not appear, however, to be any readily-discernible connection between this body of theoretical and empirical work and my experience, as a lecturer, of listening to nursing students' discussions of decision-making in patient care. Nor did it reflect my earlier experiences of working as a nurse within clinical settings. Friends, colleagues and I neither vocalised, nor appeared to demonstrate in practice, any clearly-identifiable rendition of the moral reasoning explicated by Kohlberg, Gilligan, or their adherents. Rather, the reasoning used in practice as a basis for care decisions comprised a more iterative process. The context within which decision-making took place was influential, whether in relation to the specific individuals involved in substantive situations, or to organisational factors, such as staffing levels.

It appeared, then, from my experiences in both clinical practice and university settings, that the theoretical approaches provide, at best, a partial and over-simplified, rather than comprehensive, depiction of the moral domain of nurses in practice. The advantage of such approaches is that they appear clear and concise, but I shall argue that, if the result is a misleadingly neat and simplistic depiction of the moral work involved in patient care, then it is both necessary and desirable to accept that the complexities of moral reasoning require a more discursive approach. That little of the extant literature developed within the nursing arena uses the latter approach, appears unfortunate. The work of writers who have proposed a less narrowly-focused and more integrated perspective, but who are seldom cited within the nursing literature related to moral reasoning and student experience, will be described and discussed within the literature review and in relation to the data from my study, as this work appears to have greater explanatory relevance for the students' accounts.

Having provided the intellectual background to the study, the practical background was as follows. On commencement of my part-time PhD studies in October 1995, I was a lecturer within the Foundation Studies Department of a College of Health Studies, which provided a three year Programme, leading to the

award of a Higher Education Diploma in Nursing.[1] Part of my job remit entailed leadership of what was entitled the *professional, ethical, moral* theme, during the Foundation Studies (ie initial 18 months) component of the programme. Teaching staff within the theme used scenarios, video footage and the students' own descriptions (written and verbal) from practice placement experiences, in order to provide a basis for discussion and identification of the underpinning principles used by the students to support their own position in relation to professional, ethical and moral aspects of care. From this information an introduction to utilitarian and deontological thinking and the implications of their application to health care settings was derived, as were the principles of non-maleficience, beneficience, autonomy and justice. The rationale for this approach to the material was that the introduction of philosophical principles and theories in the abstract might have proved daunting, to say nothing of boring and irrelevant, to at least some of the students.[2] It was of interest, however, that a common complaint from students when presented with scenarios, was that these provided insufficient information upon which to base decision-making.[3] An outline of the theories of Kohlberg and Gilligan were provided within the social and behavioural science component of the curriculum, although this was not an area in which I had any teaching commitment.

As will be seen from the literature review which comprises Chapter Two, the research that has been carried out in relation to the perceptions of care and the moral functioning of nurses has, in the main, operated from the perspective of the theories of Kohlberg or Gilligan and is, for the most part, quantitative in approach. Thus, participants' responses to questionnaires, or structured interviews, are allocated to pre-determined categories. It is, then, an increasing awareness over time of the apparent mis-match between the influential extant theories and my own

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[1] Details of the students' programme of study, and the background to its development, are outlined in Appendix I.

[2] Use of hypothetical scenarios, such as those favoured by some philosophers, in which discussion focuses upon whom to save whilst adrift on a life-raft, seem similarly dislocated from the likely experience of students during their practice placement allocations. The teaching team within the theme considered it important to situate discussion of theoretical issues within the context of everyday realities.

[3] As will be discussed in Chapter Four, the findings from my study suggest that this may be due to the centrality of context in the students' moral reasoning and decision-making processes.

experiences and those of students and colleagues, within both academic and clinical settings, that has prompted a desire to explore, by *qualitative* means, the students' perceptions of care.

Thesis structure

A grounded theory approach is appropriate for exploration of areas about which there is little research evidence. Literature reviews may thus be short in the initial instance, as literature is sought throughout a study, in order to illuminate areas which emerge from data analysis as being of relevance. Indeed, Glaser and Strauss (1967:p253) and Glaser (1992:pp31-34) advise against researchers reading literature in their substantive field of interest lest this lead to preconceptions about their own data. Whilst it is clear that, within a grounded theory approach, literature should be sought *throughout* a study, there are a number of problems in following Glaser and Strauss' advice. The first is that development of interest in a particular area may stimulate a literature search prior to any firm intention to undertake research. My own initial interest in student nurses' perceptions of client care led me to seek relevant research. The second problem, related to the first, is that a literature review is a prerequisite for identification of current knowledge and formulation of appropriate research questions.

In my own area of interest, student nurses receive input in relation to the moral reasoning theories of Kohlberg and Gilligan, upon whose work many of the studies which explore the moral reasoning of nurses is founded. On both these counts the work of Kohlberg and Gilligan is influential and it is therefore important to review it in some depth, to facilitate its comparison to the accounts provided by the students within my own study. Thus, the literature review (Chapter Two) within this thesis is rather more extensive than might be expected within a grounded theory approach. Within Chapters Four and Five, I explore the relationship between the literature and the findings from my own study, but Chapter Two provides additional comment in relation to this, where appropriate.

The literature review (Chapter Two) is presented in two sections. The first section examines the concept of care and some of the empirical studies which have attempted its measurement. The second section describes the theoretical

perspectives which have been influential in directing the form that research into the moral reasoning of student nurses has taken.

Chapter Three provides a discussion of the methodological issues and procedures relevant to my study. A qualitative study, using grounded theory, the underpinning philosophical basis of which is symbolic interactionism, was deemed appropriate, given that there is scant research that provides a qualitative approach to the students' perspective of care. The method used to obtain data was in-depth interviewing of a small group of volunteers, who were undertaking a three-year Diploma of Higher Education in Nursing programme. The strengths and weaknesses of the approach and method, and the rationale for their use, will be explicated.

The findings from the study are presented in Chapter Four and, for the purpose of analytical clarity, are discussed in two discrete sections, which reflect the organisation of material in the literature review. The first section explores the students' conception of care *as it relates to nursing work*, as this appeared to be a pre-requisite for subsequent exploration of their perceptions of care quality. The second section builds upon the first, in order to explore the students' perceptions of the patient/client care that they encountered, and in which they participated, during their practice placement allocations.

Chapter Five provides a synthesis of the study, situates its findings in relation to the literature and focuses on the contribution that the thesis makes to knowledge. Some implications of the findings are suggested.

CHAPTER TWO

LITERATURE REVIEW

Introduction

The literature review is presented in two sections. The rationale for this division is that, whilst there is a degree of interdependence between the material in each part, their separation is necessary for analytical clarity. The first section provides theoretical and/or empirical accounts of the concept of care and caring, as this appears to be a prerequisite for subsequent discussion of the student nurses' perceptions of care as related to nursing work. Section Two reviews literature that relates to moral development and moral reasoning, describing the work of influential writers and their impact upon the approach adopted by subsequent writers and researchers. The purpose of the literature review is to situate the extant work in relation to the data generated by the students within my own study. (The layout of material in the literature review is subsequently reflected by a similar presentation of the findings from my own study within Chapter Four.)

The remit of my initial literature search, prior to commencement of data collection, was to access studies which explored, described, or discussed the perspectives of student nurses in relation to the care delivery that they encountered whilst undertaking practice placement allocations during their educational programme. Of particular interest was research which related to the moral reasoning employed by student nurses.

Glaser and Strauss (1967:p253) and, more emphatically, Glaser (1992:p31-34) warn against researchers reading literature in their substantive area of study, for fear that it 'derails' them and that they then seek out in their own research what they think from the work of others will be present. There are, however, problems in attempting to adopt this approach. In my own instance, I had pre-existing knowledge of some of the research undertaken in areas of relevance to my proposed study and, prior to commencement of data collection, I undertook an extensive literature search in order to identify the amount and nature of the extant work. This process seemed a prerequisite for identification of theoretical

approaches and empirical work of potential relevance and to attempt to ignore it seemed, not only disingenuous, but foolhardy. It seemed to me reasonable to acknowledge the existence of the literature, but ensure that it was used as an adjunct to ideas generated by the interview data and that it was the latter which drove the direction of the study. As themes emerged from the data during the course of my study, I sought material pertaining to these, in order to explore their potential relevance.

Literature Review
Section One: The concept of 'care'

As the remit of my study is an exploration and analysis of student nurses' perceptions of care, the purpose of this section of the literature review is to outline some of the theoretical and empirical work which has been devoted to the conceptualisation of care as it relates to nursing work. (Some limited discussion of this topic will also take place within the second section of the literature review, in which the potential relevance of the work of Gilligan and Noddings for nursing practice are described and evaluated.) The intention within Section One is to identify the diversity which exists within the plethora of published work on the concept of care and to establish its relationship to nursing and to my own study. Whilst I was familiar with some of the theoretical and empirical work prior to undertaking my own study, other aspects were pursued as a result of the data which emerged from my interviews with the students. Within Chapter Four, which presents and discusses the study's findings, further reference will be made to some of the literature outlined in this current chapter.

Deconstruction, and construction, of the concept of care has been undertaken from a variety of epistemological standpoints. Gaut (1983) provided an influential, much-cited, account, in which she emphasises the requirement to develop a theoretically-adequate description of care. She identifies that the concept has a special place within nursing theories, and that it had been the subject of increased interest and comment during the ten years prior to her paper, but that this had been accompanied by only limited systematic study of the concept per se.

Gaut (1983) argues that if:

> ...the nursing profession is attempting to develop a body of knowledge
> through research, the language used to define theoretical concepts must be
> precise, unambiguous, and readily communicated.
> (Gaut 1983:p313)

From the above statement it may be surmised that Gaut's purpose in concept
clarification is enhancement of the credibility of nursing theory and nursing
research in relation to external scrutiny, with the aim of increasing the recognition
of nursing as a discipline in its own right.

Gaut (1983) states that the aim of her paper is to start a movement to remedy the
lack of conceptual clarity by means of philosophical analysis, which would
consider the notion of care as an activity and identify the conditions which must
prevail prior to designation of an activity as 'care'. Gaut identifies five conditions
that would fulfil this function. These comprise; an awareness within the carer of
the situation in which care activity was required, the knowledge base from which
to provide care, the intention to care, and access to the means by which positive
change(s) could be achieved in the person cared for, this assessment of 'positive
change' being person-specific and context-specific (as opposed to being
conceptualised in the abstract). The fifth condition is implementation of care.
This requirement for individualised, substantive detail as a prerequisite for care
delivery links with the perceptions of the students within my own study and will be
discussed further in Chapter Four.

Thomas (1993), writing from a sociological perspective, highlights the fact that the
concept of care is defined in different ways, although the epistemological base
upon which comment is founded is seldom explicated. She points out that the
meaning of care is often taken as read, whereas the concepts used provide only
partial representations of the totality of caring (p649). This is not problematic per
se, but becomes so when definitions are presented as though they constitute the
concept in toto. For example, care is frequently presented by writers as being a
generic concept, whereas examination of their work reveals it to be
situation-specific eg confined to the domestic or to the public arena. When this
occurs, the forms of care that occur outwith the context that the author has in
mind are occluded from view and thus the variety of meanings attached to the
concept by different writers and researchers results in obfuscation, rather than

clarification. Thomas queries whether care is, in itself, a theoretical category or, rather, whether forms of care constitute empirical categories which require analysis in terms of other theoretical categories (ie whether care constitutes a free-standing conceptual entity, or whether it is a sub-division of another category) and argues that it is the latter.

Thomas (1993) emphasises that any theoretical approach to care necessitates gender analysis, as care has been, and remains, a predominantly and traditionally female activity. Whilst Thomas does not specify the form which the gender analysis should take in specific settings, it is worthwhile to note that, within a healthcare setting, the association of care with nurses' and women's work has as its counterpoint, cure, agentic in nature and thus traditionally the preserve of men, in this instance medical staff.

Dunlop (1986) similarly identifies the importance of acknowledging the historical legacy of caring, in particular its frequent association with low-status work requiring little, or no, formal preparation for its practice and the care-provider's receipt of little, or no, financial recompense for its delivery. This provides a marked contrast to the longstanding association of cure with power, control and status. At the time at which Dunlop's paper was written (and arguably of equal applicability today), she argues that the concept of care as it might relate to nursing is in the process of construction and that this process might be viewed as a response to the movement of care from the private domain of its traditional delivery, into the public arena. Dunlop concludes that further concept development is required, in conjunction with an acknowledgement and examination of the organisational frameworks within which care delivery takes place.

Thomas's (1993) approach involves identification of analytically discrete, but empirically interdependent, dimensions of care. These comprise the social identities of the carer and care recipient, the relationships (interpersonal and economic) which exist between these individuals, the nature of the care (ie caring *about* and/or caring *for*, the former involving mainly affective states and the latter psychomotor activities) and the social domain (private or public) within which the care is provided/received (p651-654). Care as it relates to nursing, in Thomas's conception, would have its place within these dimensions, a rather different stance from that which proposes that caring is somehow *the* significant distinguishing

feature of nursing. This latter position is advocated by a number of writers, Jean Watson being one influential, frequently-cited example, whose work will be outlined and discussed later within this section.

Kitson (1987) attempts to untangle some of the differences between what is perceived as being 'ordinary (ie lay) caring' and that which is perceived as 'professional' or 'nursing' care. She does this by comparing and contrasting the main components of each system and concludes that:

> Finally what differentiates lay care from professional care ought neither to be its impersonal nature nor its complexity but rather the fact that it is providing those aspects of care which the lay carer (or the person himself) cannot provide because of lack of commitment, resources, knowledge or skill. (Kitson 1987:pl64)

Davies (1995a) differentiates between *caregiving work*, which refers to caring carried out on an unpaid basis within networks of family and friends and which has provided a major focus of writing on the subject within the UK, *carework*, used by Davies to refer to a variety of paid jobs within the health and social services (for example, home helps) and *professional care*, which refers to caring work carried out within the public sphere and for which the carers have received systematic and formal preparation for practice (ppl8-20). Whilst it is clearly the latter which is of substantive relevance to this study, the impact which the idea of care provision as something which originates in the domestic sphere and which has been, and continues to be, carried out for the most part by women, is clearly of significance in relation to the status of those who carry out work seen to derive from a similar root, albeit in a different (and paid) setting. It is important therefore to acknowledge the work that has provided exploration and analysis of the former, in order better to identify the standing, and potential contingent problems, of the latter.

Morse et al (1996) state that a concept is "...an abstract representation of a phenomenon" (p389) and that its definition should include its characteristics, boundaries, preconditions and outcomes (p386). They state that understanding of a concept should not be confined to its application within a single setting, but should include comparison of its relevance within one area to that within a variety of disciplines and contexts. Morse et al comment that, in relation to caring, conceptualisation differs both within and between disciplines and, additionally,

that discrepancies may exist between the theoretical description of a concept and its application in practice.

Earlier work by Morse et al (1990) in relation to conceptualisations of caring states that, whilst a number of epistemological perspectives exist, caring as a concept remains elusive and there is a lack of consensus in its definition, in its components and in the processes by which its delivery is achieved. Morse et al (1990) describe research which they carried out, involving identification, by means of content analysis, of thirty-five authors' definitions of caring (as related to nursing) and the main characteristics of their perspectives.

Morse et al (1990) identify that one dominant view has been the concept of caring as an inherent human trait, an approach taken by such influential writers as Benner and Wrubel (1989), Leininger (1988), Roach (1987) and Watson (1988). Morse et al (1990:p5) comment that the above authors minimise, or ignore, the effect(s) of the organisational framework within which care delivery takes place upon the ability of the individual carer to provide it. Whilst the theoretical perspective underpinning my own study is that of symbolic interactionism, I shall argue in Chapter Three and Chapter Four that the structural and organisational framework within which care takes place will maximise, or constrain, the range of interactions available to individuals. The students' accounts within my own study demonstrate an awareness, which increased over time, of the impact of such structures.

Morse et al (1990) also note that most authors who adhere to the view that caring is an inherent human trait tend to imply, if not overtly state, that nurses are, or should be, more caring than non-nurses and, indeed, that caring constitutes a moral imperative.

It is perhaps appropriate at this juncture to describe Jean Watson's views in greater detail, as her work has been highly influential in some quarters. Watson (1988) proposes that:

> Nursing is the profession that has an ethical and social responsibility to both individuals and society to be the caretaker of care and the vanguard of society's human care needs now and in the future.
> (Watson 1988:p32)

She suggests that the nurse/patient relationship transcends physical and psycho-social interaction and her list of ten 'carative factors' (Watson 1979), whilst presupposing the nurse's knowledge base and clinical competence, moves beyond this to include concepts of altruism and spiritual connection (Watson 1979:p75). She states that:

> The goal of nursing proposed is to help persons gain a higher degree of harmony within the mind, body and soul which generates self-knowledge, self-reverence, self-healing, and self-care processes while allowing increasing diversity...[via] human-to-human caring process and caring transactions that respond to the subjective inner world of the person in such a way that the nurse helps individuals find meaning in their existence, disharmony, suffering, and turmoil and promotes self-control, choice and self-determination with the health-illness decisions. (Watson 1979:p49)

In a later work, Watson (1990) again emphasised the need for nursing care to involve more than technical competence, in what she terms, "...caring knowledge that enriches the soul..." (p19).

As stated earlier, the work of Watson has provided inspiration for much subsequent theoretical writing. When viewed in the light of the realities of nursing practice, however, it is problematic. Aside from the views of individual practitioners as to whether or not the metaphysical encounters which Watson advocates are desirable, or indeed appropriate within nursing practice, there is additionally the logistical problem that, in most care-settings, the depth of interpersonal interaction required to implement what Watson defines as constituting care is impossible. The capacity of individuals to provide the care that she advocates is debatable, as it would appear to require super-human endeavour, and the influence of organisational constraints is ignored. Devotion of the quantity and quality of attention which Watson emphasises is a prerequisite for nursing care would, in the reality of most care settings, be unachievable and/or necessitate neglect of some clients at the expense of others and engender feelings of frustration, failure and guilt.

These foregoing comments are made on practical grounds, but there remains the more fundamental question as to whether such interaction is desirable, even if attainable, within any, or all, nurse/client relationships. Additionally, within Watson's writings psychomotor competence is accorded only passing

acknowledgement and is devalued in favour of affect. Whilst the relevance, or otherwise, of Watson's theories to the data from the students within my own study will be addressed in detail in the presentation and discussion of the findings within Chapter Four, it should perhaps be noted at this point that their accounts did not subscribe to such a view. The students' concept of care accorded high value to psychomotor competency, not as an end in itself, but as a means of attaining the optimum standard of overall care for patients.

Some of the authors examined in Morse et al's (1990) study place emphasis upon affect, others upon nursing interventions, some focus upon interpersonal relationships between nurses and clients, and most adopt the perspective of the nurse, without explicit reference to the client's experience. In many of the studies the writers' own personal views were evident, but the impact of this subjectivity upon the approach taken was not always acknowledged.

Morse et al (1990) also examines the theories of caring in relation to nursing, which have been (and continue to be) influential. Orem's (1985) self-care model, which operates upon the assumption that autonomy and self-care constitute the desirable means of existence, is criticised for its cultural specificity and its unquestioned assumption of the universalisability of 'western' cultural values and subseqent acceptance of these by carers and clients. Watson's (1988) theory of human care is criticised for its emphasis upon affect at the expense of psychomotor skills and for being unachievable in practice. Leininger's (1981a, 1981b, 1988) perspective differentiates between caring as a generic term, as a professional statement and as what she terms a professional nursing viewpoint. The aspects identified by Leininger all include psychomotor behaviours as well as affective states.

The diversity of views on the concept of care, coupled with the lack of consensus on underpinning theory, led Morse et al (1990) to conclude that, if 'caring' is to be regarded as the essence of nursing, and if research in the area is to advance, then there is a need for concept clarification.

The lack of consensus in concept definition is also identified by Webb (1996) as problematic. She provides a list, in table form, of more than thirty words identified from nursing literature as being associated with care (p962) and this serves to highlight the confusion and ambiguity attendant upon attempts at one

definitive explication of the concept. Webb identifies that one source of the difficulty lies in the lack of agreement in the conceptualisation of nursing itself. She cites Dunlop (1986) as stating that, if nursing is considered to be caring, then the term 'nursing care' is rendered tautologous. Duke and Copp (1992) suggest that care, as it relates to nursing, comprises more than a simplistic itemisation of its component parts, but that its invisibility renders explication and public acknowledgement problematic.

Sourial (1997) searched the nursing literature for uses of the concept of caring and found that, whilst some writers consider it to be the defining characteristic and raison d'être of nursing, others argue that although nursing is one form of caring, caring also occurs outwith its jurisdiction and, therefore, that nursing's claim to unique status is unsustainable.

Sourial uses one part of a method of concept analysis, cited within Walker and Avant (1995), which entails identification of all uses of the concept that can be found. In relation to nursing, Sourial found a number of different usages, comprising some, or all, of the following aspects: an ethic of care, affect and/or instrumental behaviours, perceptions of nurses and/or patients, holism, humanism, logistics of care delivery, the effect of the organisation and the quality of care provision.

Sourial (1997:pll90) suggests that, within existing organisational frameworks, instrumental care is easier to provide than affective. This is due to the requirement of any organisation to look beyond the needs of individuals per se and to adopt a wider, more utilitarian perspective, which may result in conflict between a philosophy of care as espoused by nursing and the philosophy of the organisation. Sourial's conclusion, that caring has numerous interpretations, concurs with that of other writers.

Kyle (1995) provides a review of literature related to the concept of caring as applied to nursing work and focuses upon the methods of study utilised by researchers. She states that the majority adopted a quantitative approach, in which the need to identify specific behaviours indicative of caring (in an attempt to operationalise the concept) is central. Kyle also points out that the majority of studies emanate from the USA and that there may be cultural (and, arguably,

organisational) differences which render transferability to a UK setting problematic.

Kyle (1995) describes Larson's (1984, 1986) Q-Sort research studies, some of which focused upon the patients' perceptions of care and some upon those of the nurses. Within a Q-Sort study items are identified by the researcher as being relevant to the area under study and participants are asked to rank these in order of importance. The responses of participants are subsequently coded and statistically analysed. (In relation to the nurses' responses, Larson reported that several participants stated that they would have preferred to respond twice; once from their perspective as nurses and then rating what they perceived would be of importance to patients. This indicates awareness on the part of the nurses that their own perceptions are unlikely to be universally held.) The use of pre-determined items places obvious limitations upon participants, as does the requirement to rank these in the abstract, without reference to a concrete situation. Additionally, the items ranked as being of 'least importance' are only so in relation to those considered to be of 'most importance' ie they are not necessarily considered to be unimportant per se. Despite these identified limitations it is an approach that has been adopted by a number of researchers. Kyle (1995) points out that most of the subsequent studies which utilised Q-Sort (for example von Essen and Sjoden 1991) have predicated the reliability and validity of their own Q-Sort upon Larson's (1984, 1986) findings, rather than attempting to confirm the reliability and validity of Larson's Q-Sort. (One can, of course, also question whether use of tools such as Q-Sort reveal more about the researchers' views on a subject than they do about those of the participants.)

Kyle (1995) also identifies utilisation of caring behaviour inventories by some researchers, for example Wolf (1986) and Cronin and Harrison (1988), but suggests that this approach is still relatively untested in relation to reliability and validity.

Kyle (1995) comments that the use of quantitative methods as a means of research into caring is problematic, in that the concept is too complex to be rendered down to a series of caring behaviours and that, although most researchers acknowledge this in passing, they then proceed to attempt operationalisation of the concept by means of a behavioural approach. Kyle is also critical of the pre-determined nature of the items in quantitative approaches and the subsequent lack of participant choice, or of the opportunity to provide qualifying comment(s).

Qualitative research on caring similarly raises problems specific to the selected method of study. Morrison (1991)[1] uses Kelly's Repertory Grid interview technique, identifying by content analysis seven categories related to qualified nurses' perceptions of caring in nursing practice. These categories were obtained from a total of two hundred verbal constructs of caring obtained by means of interviews with twenty-five charge nurses. The categories were those which related to the personal qualities of the nurse, their approach to clinical work, interpersonal skills, motivation, consideration of others, time-management and attitudes. Relatively few constructs related to psychomotor aspects of care. As was stated earlier, the students in my own study place importance upon acquisition of relevant psychomotor skills[2]. Some identify, however, that, in their early practice placement allocations, anxiety in relation to attainment of psychomotor competence results in 'tunnel vision', with a consequent focus upon the physical skill as an activity *in itself*, as opposed to *one part* of a total patient care package. It was only following development of psychomotor competence that the students became able to view patient care <u>in toto</u> and take their own psychomotor skills for granted. It is possible, then, that in studies which report that experienced registered nurses appear to place less emphasis upon physical care than upon psychosocial care, this is because the participants take the former to be a <u>sine qua non</u> which does not require explicit identification.

Kyle (1995) cites Pegram (1992), who interviewed twenty-eight registered nurses about their perceptions of caring and used content analysis to identify a number of categories related to caring; its meaning, activities and attitudes inherent in its implementation, physical and psychological aspects, the relationship between caring and nursing, the relationship to professionalism and the differentiation between caring *for* and caring *about*. Pegram's study appears to indicate a greater focus on physical aspects than did that of Morrison (1991), but Kyle states that she

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[1]Although Kyle (1995) cites Morrison (1991), the use of Kelly's Repertory Grid is also reported in Morrison (1989).
[2]This was not a finding that was Branch-specific, ie it might be expected that students undertaking the Adult Physical Health Branch would accord greater emphasis to psychomotor skills, as physical care activities have a greater association with these settings, but this was not the case.

was unable to obtain more than superficial details of the method and conduct of the study.[3]

Kyle (1995) also highlights the differences which have been identified between patients' and nurses' perspectives on the important elements of care, the former tending to place greater emphasis upon psychomotor aspects of care than do nurses.[4] (It should also be noted that studies that examine care from the client's perspective are relatively few in number, although there has been an increasing focus upon this approach in recent years.)

Kyle concludes that the extant literature highlights caring as a complex entity, comprising more than a set of caring behaviours and necessitating recognition of the importance of its less operationisable aspects, such as the moral, cognitive, emotional and cultural domains. For this reason, she advocates qualitative approaches as being the preferred method of investigation of the concept of care as it relates to nursing.

McCance et al (1997) similarly state that caring as a concept is difficult to define and they use the work of Walker and Avant (1995) in order to attempt clarification, although they acknowledge that some writers (for example Morse 1995) criticised Walker and Avant's model as being a linear and positivist over-simplification of a complex concept, use of which resulted in trivialisation of some elements. Morse (1995) favoured the model of Rodgers (1989), but McCance et al (1997) consider that, despite the limitations of Walker and Avant's model, it has the advantage of being widely used and well-established in the work of frequently-cited writers. McCance et al additionally incorporate some of Rodgers' (1989) material and conclude that use of the model enables identification of four critical attributes of caring; serious attention, concern, providing for and getting to know the patient.

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[3] This latter comment raises a commonly-experienced concern, in that the detail of any study is, of necessity, truncated within journal articles and this then raises questions within the reader's mind, which are problematic to resolve in the absence of further explication.

[4] There are, of course, a number of explanations for this finding. Apart from the obvious one, ie that patients place less, and nurses more, emphasis on affective aspects, it is possible, for example, that nurses operate upon the assumption that psychomotor competence is fundamental and does not require explicit mention.

McCance et al (1997) additionally identify prerequisites for caring to take place, these being the amount of time available, respect for persons and an intention to care. They also point out that, whilst the consequences of caring are difficult to identify clearly, the effects of a lack of care are more readily discernible. This latter comment links with those made earlier about the invisibility of care provision, resulting in it being taken for granted and thus accorded little or no public acknowledgement.

Beck (1999) identifies the problematic nature of the concept of care, in relation to both definition and measurement and reviews eleven quantitative instruments used by researchers. Beck provides details of the instruments, seven of which comprise Likert scales, two visual analogue scales, one a checklist and one a Q-sort, and explicates the way in which these are employed within the studies reviewed. Comparison of the different tools identifies that, whilst each measures an aspect of caring, none is definitive. Beck argues that multiple factors require to be taken into account if contemplating using one of the extant quantitative tools, each for example being predicated upon rather different conceptualisations of caring. This, of course, leads back to the necessity for a clear explication of any concept prior to attempts at its evaluation.

Lea and Watson (1996) provide a selective review of literature, outlining the views of major theorists on the concept of caring as related to nursing. The authors sought to identify contrasts between theoretical perspectives, compare the research methods applied to caring in nursing and provide a brief review of some of the published research. Their purpose was to utilise the foregoing as material from which to develop an inventory with which they could investigate perceptions of caring amongst nurses (p72). Lea and Watson (1996) identify what they term a dichotomy between the existential theorists, such as Watson (1988) and others and proposed that this dichotomy is parallelled in the approaches to research, the existential theorists favouring qualitative approaches. Whilst they acknowledge that Watson (1988) represents what they termed the 'extreme' end of the qualitative school and that the qualitative approaches of some writers have aided clarification of concepts within caring and thus provided a foundation for further

qualitative and quantitative work, Lea et al (1998) nonetheless state that:

> ...Those who take an existential view of caring in nursing tend to rely on qualitative methods (Leininger 1981, Watson 1988), usually eschewing the possibility that it can be measured in any meaningful [sic] way. On the other hand, several investigators, including some who view caring in nursing from a largely existential point of view (Gaut 1986), are not averse to operationalizing caring variables in order to study them by means, for example, of direct observation or questionnaire surveys...
> (Lea et al 1998:p663)

Lea and Watson's (1996) review of the literature concludes that caring is a complex phenomenon without clear definition and is thus open to a variety of conceptualisations. Whilst they acknowledge the contribution of qualitative research approaches, they state that the volume of complex data obtained from such studies is problematic, as it complicates, rather than clarifies, the concept under scrutiny. They argue that, "...There is a need to reduce caring to underlying dimensions in order to understand its structure better..." (p75) and propose that this is achievable by quantitative methods, citing Valentine's (1991) comment that, in order for nursing to advance caring, "...it must also advance the empirical measurement of caring in such a way that withstands the scrutiny of the scientific community." It is, of course, possible to argue that, if a concept is complex, its distillation to a series of operationalisable (in quantifiable terms) items will advance understanding only in a simplistic, reductionist sense. In relation to Valentine's comment, whilst the scrutiny of the scientific community is clearly of pragmatic importance due to the power which its influence exerts within our society (for example in relation to the award of research grants), it is arguable that this fact should not necessitate a slavish adherence to its tenets if these are inappropriate, or inadequate, for the area under study.

The work of Watson and Lea

Watson and Lea (1997) designed the 'Caring Dimensions Inventory' (CDI), with the purpose of conducting large-scale studies into nurses' perceptions of care. As this inventory provides the basis for their subsequent studies (Lea et al 1998, Watson et al 1999a, Watson et al 1999b), it seems necessary to describe it in some detail prior to evaluation of its suitability in practice. The first section (nine questions) of the CDI gathers demographic data from respondents. The subsequent four questions aim to gain information as to the importance accorded

by respondents to the concept of caring as related to nursing and to assess their awareness of the extant literature on the subject. A core question is then asked of respondents, "Do you consider the following aspects of your nursing practice to be caring?" and this is followed by twenty-five statements, which respondents are asked to assess, using a five-point Likert scale (Watson and Lea 1997:p88). Following this, respondents are asked three further questions relating to their knowledge-sources.

Watson and Lea's (1997) paper focuses upon the provenance of the twenty-five statements relating to care and the authors' analysis of respondents' replies. The content of the statements was derived from a literature search, which concentrated on key authors and papers widely cited in the nursing literature on the subject of caring. Watson and Lea (1997) state that:

> Clearly, in view of the different theoretical perspectives on caring it was necessary to confine the review to authors who believed that it was possible to operationalize caring in the way which was required for construction of the CDI.
> (Watson and Lea 1997:p88)

Watson and Lea (1997) pay specific attention to empirical studies, rather than work which adopts a purely theoretical approach. So it is clear from the outset that the foundation upon which their questionnaire is constructed is highly-selective and predicated upon a particular perspective. In addition to peer-reviewed academic journals, Watson and Lea reviewed articles in what they termed the 'popular' UK nursing journals, in order to determine the presentation of the concept of caring within these. The review was achieved by selection of articles in which the words 'care' or 'caring' appeared within the title, or in the listing of key words. A total of sixty-three articles were included in Watson and Lea's review and were subsequently coded by Lea on the basis of fourteen themes that she identified from their content (1997:p89).

Watson and Lea's initial (1997) study using the CDI was carried out by means of a postal survey, distributed to 3024 qualified and student nurses, with a response rate of 47%. Data were analysed using SPSS and Mokken Scaling procedures. On the basis of their initial findings, Watson and Lea (1997:p92) suggest that the CDI may provide a more formal basis for measurement and comparison of different groups of nurses than has been possible hitherto.

Watson et al's (l999a) study reports on the use of the CDI, in conjunction with a Nursing Dimensions Inventory (NDI), which the authors developed from the former instrument. The NDI contains items analagous to those within the CDI, and uses a five-point Likert scale, but the stem question in the NDI asks respondents, "As a nurse it is/will be important for me to:", followed by a list of items. Its purpose is to identify whether nurses differentiate between 'caring' and 'nursing' and whether they respond to the CDI questions on the basis of what they feel to be of importance in nursing. It should perhaps be noted that the title of their paper, "A longitudinal study into the perceptions of caring and nursing among student nurses", is slightly misleading, as the study in fact involves the students being asked to rank the perceptions of others.

Watson et al's (l999a) study was longitudinal, data being collected from student nurses upon their entry into nurse education (time one) and twelve months' later (time two). The authors attribute the significant change in scores for some items between time one and time two to a loss of student idealism. The word 'idealism' is not defined by the authors, nor is it used within the questionnaire, but the examples which the authors identify as being indicative of a loss of idealism are that the students attach decreased importance at time two to 'staying at work late' and 'coming in when sick', whereas the items 'exploration of patients' lifestyle' and 'helping patients participate in care' increase in importance. Consistently ranked as most important is 'listening to patients'.

Watson et al's (l999a) findings indicate that men accord more emphasis to the psychosocial aspects of nursing than do women and that older respondents rate the technical aspects of care more highly than do those who are younger. In their later (Watson et al 1999b:pl087) study, the authors state that, "It would appear that that there are inherent differences in the perception of caring on the basis of age." The authors' use of the word 'inherent' is not defined and it is therefore unclear whether they mean that the differences in perception are invariably present in all older individuals, or whether the differences are resultant from the increased life experiences contingent to increased age or, indeed, whether they mean that older individuals perceive inventory completion in a different way to younger individuals.

Watson et al's (l999a) findings also indicate that, on commencement of the students' programme, there is some disparity between the students' perceptions of

nursing actions as caring and the importance of these as 'nursing' actions. The replies to the CDI and NDI are more congruent at time two. Watson et al (1999a) note that there are what they perceive as inconsistencies in the students' responses, for example although 'listening to a patient' is highly endorsed, 'sitting with a patient' is not. The authors consider the latter to be of importance in achievement of the former, but speculate that perhaps sitting with a patient is still frowned upon in some placement areas or, alternatively, that the students may have found the item 'sitting with a patient' less clear than 'listening to a patient'.

Watson et al (1999a) conclude that the aims of their study, ie establishing if changes in students' perceptions of nursing actions alter over time and whether they perceive nursing and caring as being synonymous, have been successfully achieved. In their conclusion the authors suggest that:

> ...The fact that perceptions of nursing change should also be relevant to nurse educators who should be motivated to discover if such changes are a natural process resulting from general exposure to the various aspects of nurse education or whether they are specific to the programmes undertaken. Also, it should be possible to discern if such changes occur as a result of the academic component or the clinical component of nurse education. It may even be possible to manipulate programmes of nurse education in order to achieve desired perceptions of nursing at particular points.
> (Watson et al 1999a:p1237)

A continuation of the (1999a) work was reported by Watson et al (1999b) and provides details of the data collected from the same cohort of students (n=168 at commencement of the study), at the end of the second year of their programme (time three). On the occasion of this last data-gathering exercise 54% of the original sample (n=90) remained. This (1999b) paper details the authors' use of factor analysis, in an attempt to reduce the multivariate data to fewer underpinning dimensions, or factors, which are explanatory of the data as a whole. The authors use principal components analysis (PCA), followed by oblique rotation of the data in order to achieve this.

Watson et al (1999b) state that the student nurses in their study demonstrate increased perception of the professional and technical aspects of caring over time and that older students perceive caring in more professional and technical terms than do younger ones. The authors also state that they found evidence, at time three, of a factor of accountability, suggested by reference to lines of

communication with healthcare colleagues and patients and documentation of care provision. They attribute this to an increasing professionalisation amongst the students due to educational input, clinical practice and an ability to view nursing in a wider context, although they concede that this finding might be specific to their own study and recommend further work to replicate their study in other centres, in order to assess the statistical generalisability of findings.

The foregoing studies by Watson, Deary and Lea have been described and evaluated at some length due to their high publication profile over the past three years and due to the authors' claims that their methods afford a reliable and valid means of operationalising caring and of evaluating its perception by nurses in a 'meaningful' and 'formal' manner. It is, of course, possible to suggest that their fundamental premise, ie that it is possible to encapsulate a concept such as caring by such methods, is over-sanguine.

Whilst Watson and Lea (1997:p92) state that, "Caring is an elusive phenomenon and is unlikely to be composed of a single construct", their data collection and analysis methods fail to acknowledge that it is a phenomenon which is arguably, to some extent, context-dependent, the operationalisation of which will then vary according to the specific individuals involved in its delivery and reception and the substantive situation in which these individuals are located. In their apparent assumption that perceptions of care identified in the abstract may be extrapolated to the realities of practice, it may be that Watson et al (1997) have simplified the construct at the expense of accuracy and relevance. However, an inherent risk of research methods which preclude the opportunity for participants to explicate or qualify their responses, is their potential to produce findings and conclusions which have clarity and precision at the expense of explanatory power and depth. My personal disquiet in relation to Watson et al's studies stems, not from the fact that there appear to be limitations to the conclusions which may be drawn from their findings, nor that the findings from such a study provide limited insight into perceptions of caring (which is probably inevitable in any method used to investigate such a complex concept). It is, rather, that the researchers appear to over-estimate the suitability of their method and analysis for the task to which it has been set and to under-estimate the impact upon findings of presenting respondents with pre-determined items to which they are then required to respond in the abstract.

In contrast to the approach of those who advocate quantitative approaches to the study of the concept of care, Benner and Wrubel (1989) operate upon the assumption that caring is always specific and relational and cannot be context-free. They state that:

> ...*Caring is always understood in a context.* In other words, when the situation calls for technical proficiency, then technical proficiency (swift, accurate actions) is experienced as caring. When the patient situation does not require technical actions, expressive actions such as recognition of the patient's uniqueness are identified as caring.
> (Benner and Wrubel 1989:p5-6). [emphasis in original]

Within my own study, the students' emphasis upon context increased over time, the core category and basic social process in their determination of care quality being that of 'providing care in context'.[5]

Benner and Wrubel accord importance to the cultural heritage that associates caring with 'women's work' and consequently relegates it to the domestic, and thus publically unacknowledged, sphere. They also argue that the Western tradition of valorising the theoretical and abstract over the practical is responsible for the devaluation of nursing and thus of caring.

Reverby (1987, 1994) identifies the danger that care may be universalised as an element of women's identity, or as an inherent human quality, without recognising it as resultant from, and integral to, the cultural and structural context within which it has been created. She argues that some of those who have attempted to professionalise nursing perceive the need to promote the concept of altruism (assumed to be the foundation of caring) and to avoid demanding autonomy. She argues that this ideology remains prevalent and powerful today. Reverby argues that one reason why nurses have often rejected notions of feminism is due to a perception that claiming rights may risk devaluation of the altruistic (ie caring) aspects of nursing work.

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[5]This will be discussed in detail in Chapter Four, which presents and discusses the findings from my study.

James (1986) similarly identifies care as constituting a problematic concept. In her study of care in a hospice she found that, for staff, good care meant caring *about* patients and that listening to them was designated as an example of the foregoing. Indeed, James comments (p161) that 'listening' is a term which is sometimes used in an almost metaphysical sense, as though getting patients to talk is an end in itself. James's findings identify 'good care' as being present when nurses communicate with patients *whilst* implementing physical care. James points out that psychomotor tasks are finite, visible and structured and that this contrasts with the unlimited demands, invisible outcomes and immeasurability of 'care' (p244). Care can never be fully accomplished, whereas tasks have the capacity for completion.

James (1992a) highlights that some writers are in danger of valorising nursing to the extent of claiming a monopoly on caring. The outcome of this exclusivity is that the different occupational groups involved in the delivery of health and social care may fail to learn from one another. A comprehensive understanding of the meaning of care is, then, impossible. James (1992a) also follows the line of argument explicated earlier in her (1986) thesis, in saying that the difficulty of quantifying care renders adequate accounting for its affective effects problematic, whereas 'work', by contrast, may be measured and timetabled (1992a:p107). James suggests that work may provide a protective barrier against the limitless (and thus unachievable) demands of care and that, indeed, without the physical aspect, the emotional work would be overwhelming. Following this line of argument 'work', frequently designated as the villain of the piece, is, rather, what renders 'care' possible (1992a:p108).

James concludes that the principles of care which (some) nurses and writers advocate will be problematic, if not impossible, to realise in practice, within the current organisational constraints which operate within care settings. In James (1992b), similar comments are made, with an additional comment that it is likely to be the minutiae of nursing work which determine the quality of care (p496).

James (1992b) comments that her findings indicate an almost an inverse law of status and skill in emotional labour, those who receive the least formal preparation for practice (auxiliaries), being the staff who have the greatest amount of direct patient contact and consequent knowledge of the patient as an individual. James's

remarks are supported by some of the comments made by the students within my own study and will be further discussed in Chapter Four.

Wilkes and Wallis (1998) highlight the paucity of research into caring from the perspective of student nurses and address this deficit in their own study. They distributed questionnaires which used open-ended questions to students in two Australian tertiary institutions. In the first instance they distributed questionnaires to sixty students who were close to completion of their three year programme. Later, all nursing students in both institutions were asked to complete the questionnaires (n=approximately 900). The response rate to this, in which participation was apparently voluntary, was a surprisingly high 90%. Students were asked to describe their personal view of the meaning of care and first year students were additionally asked to describe an incident in which they had been caring to someone. The more senior students were asked to describe an incident during their previous practice placement in which they perceived themselves as being caring. Students were also asked to identify whether they agreed to being interviewed and, if so, to provide a contact number.

The total number of completed questionnaires subject to analysis was fifty-six from the sixty students in the initial part of the study and a random sample of thirty from each year of the later part of the study. No further questionnaires were subject to analysis, as saturation was considered to have been achieved by this point. Interviews with some respondents were subsequently conducted by telephone,[6] in order to allow greater in-depth exploration of responses obtained from the questionnaires. The researchers subsequently coded the data from both the questionnaires and the interviews for emergent themes.

Wilkes and Wallis (1998) cite an earlier study (Wilkes and Wallis 1993) which they carried out using Roach's (1984) categories of professional caring (compassion, confidence, conscience, competence and commitment) as the theoretical framework for allocation of data. In their 1993 study, the major attribute of caring initially displayed by nursing students was compassion, the competence and confidence aspects emerging as students progressed through their second year.

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[6]The use of telephone for interviewing was dictated by financial and logistical constraints.

Commitment and conscience were only evident during the students' third year of their programme.

Wilkes and Wallis's (1998) study was prompted by the findings of this earlier study. The themes which provide the framework for analysis appear again to have been those identified by Roach (1984, 1987, 1992), with the additions of communication, courage and concern. The first year students demonstrated caring by compassion, communication and concern, competence being evidenced only in the students' ability to refer problems to senior staff when appropriate. In second year students the communication aspect changed, in that they developed, "...a goal of 'care of the patient who is ill' and...working side-by-side with the patient rather than face-to-face" (Wilkes and Wallis 1998:p586). Also evident in second year students was increased competence of a technical and affective nature.

From their findings, Wilkes and Wallis (1998) constructed a theory of the meaning of caring for students. This combines the core notion of caring, identified by the researchers as being compassion, with caring actions which are expressed by the nurse. These latter include communication, talking, listening, explaining and touching. The first of these, communication, not only comprises an action in itself, but also provides a link between compassion and the other caring actions.

Wilkes and Wallis (1998) identify that one limitation of their study is its cross-sectional, rather than longitudinal, approach, another being the absence of direct observation of students' behaviour in practice. They also identify that the use of telephone interviewing, as opposed to face to face encounters, may have affected the nature of the communication. They suggest that further studies are required, including those which examine the effect[s] that organisational constraints may have upon the ability of individuals to care.

Summary: the concept of 'care'

From the foregoing, it is clear that, whilst the concept of care as it relates (or does not relate) to nursing work has been the subject of much theorising, study and polemic, no definitive conceptualisation has been achieved. It may be suggested that the reason for this is the complexity of the concept under study. Rather than proceed in a fruitless pursuit of one neat encapsulation of such a multi-faceted

concept, it has been my decision to describe, within the presentation of findings from my own study (ie in Chapter Four), the *students'* perceptions of the nature of care as it relates to nursing work. Within that Chapter I shall explore the relationship of the students' comments to the extant body of literature in greater detail than I have done here. In adopting this approach, I am fully aware that the students' perceptions are, of course, influenced by at least some of the writers cited within this section of the literature review and by the views of staff within university and practice placement settings. They are, additionally, influenced by their own personal qualities and life experiences and by the attitudes of society at large (all of which have, of course, also exerted influence upon the writers whose work is here reviewed).

Literature Review
Section Two: Moral Reasoning

Within Chapter One Downie and Calman (1993) and Thomson et al (2000) were cited in support of the assertion that the intimate association between nursing and the health and wellbeing of individuals and communities precludes designation of *any* elements of its practice as morally-neutral. Whilst some aspects of nursing are technical, competence or its lack has an effect upon the client's welfare. *All* decisions made, and *all* actions taken, in relation to a client's care are indivisible from their beneficial, or deleterious, outcomes. If nursing work is accepted as a moral enterprise, then evaluation of nursing care quality involves moral reasoning processes in order to arrive at moral judgements.

In order to achieve a coherent overview of the research in relation to moral reasoning it is my intention, in the first instance, to describe the theories that influence and underpin much of the work. This appears to be a pre-requisite in understanding the rationale for approaches adopted by subsequent researchers and the extent to which these appear appropriate, or otherwise, for the task to which they have been applied.

The majority of writers who have researched the moral reasoning of nurses utilise either Kohlberg's (1969, 1976, 1981, 1984) cognitive development model of justice reasoning, possibly subject to modification, or provide a critique thereof, which may propose an alternative perspective, utilising the concepts of care and concern

(Gilligan, 1982, 1993). As the theories of Kohlberg and Gilligan have been so influential within my area of interest, I shall provide a fairly detailed description and discussion of their work. This will be used to set the scene for a review of the research into nurses' moral reasoning and this review will, in turn, enable a comparison with the findings from my own study.

The work of Kohlberg

As Kohlberg (1981:p.xvii) acknowledges, his (1958) doctoral thesis was developed using the work of the child psychologist Piaget (1948) as its foundation. Kohlberg revised and reconstructed Piaget's work in order to apply it to the study of adolescents and young adults, one important elaboration being that of describing six stages of moral development as opposed to the two identified in Piaget's theory.

Although Kohlberg has published extensively in relation to his theories of moral development,[7] it is *The Philosophy of Moral Development* (1981) which will be used as the major focus for my description and discussion, as the authors who cite a primary, as opposed to secondary, source for their discussion of Kohlberg's material appear to favour this text, or an extract therefrom. The book contains a detailed account of the development and utilisation of the stages and levels of moral development which form the linchpin of Kohlberg's theory.

Kohlberg claims (1981:p.xii) that it is impossible to discuss the psychology of moral development without first answering a philosophical question as to the nature and content of virtue. He identifies this as problematic (1981:p173) when he cites Alston's (1971:p276) assertion that, "...it is notorious that moral philosophers agree no more about what is distinctive of the moral than about anything else", but Kohlberg argues that this is somewhat misleading in that, whilst there may be an infinite variety of definitions of moral behaviours, there is nonetheless a fairly high degree of agreement (amongst formalists) as to the formal properties of any moral judgement. It is in these formal properties that Kohlberg's major interest lies. He asserts that the first virtue of any individual, or society, is justice, which he defines as being equity, or equal respect, for all people (1981:pxiii). His rationale for the

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[7]For a comprehensive list, see 'Bibliography of Writings by Lawrence Kohlberg', in Kohlberg (1981: p423-428)

selection of justice is that, as mature principles are neither rules (means), nor values (ends) but are, rather, guides to the perception and integration of all morally relevant elements in concrete situations, only principles of justice have any claim to adequacy in a universal and prescriptive sense (1981:p174-5). The concept of justice as the desirable dasein for humanity originates in Socratic thought (although Kohlberg does acknowledge (1981:pxxix) that Socrates' concept of justice may well differ from that held within western societies during the latter part of the twentieth century).

Kohlberg states that, in common with most deontological philosophers since Kant, he defines:

> ...morality in terms of the formal character of a moral judgement, method, or point of view, rather than in terms of its content. Impersonality, ideality, universalisability, preemptiveness, and so on are the formal characteristics of a moral judgement.
> (Kolberg 1981:p170)

As it is these formal criteria that define judgements as moral, they may be fully met only by those at the most mature stages of moral development within Kohlberg's model and it is this greater degree of cognitive and moral maturity that renders the judgements more adequate than those made at less mature stages of moral development (1981:p170). Kohlberg emphasises that his claims for the superiority of the higher developmental stages are not claims for a system of grading the moral worth of individual people, but are, rather, claims for the greater adequacy of one form of moral thinking over another (1981:p169). With regard to any relationship which may exist between moral reasoning and moral action, Kohlberg makes the reservation that:

> What I am ready to predict is not that people in a moral situation will do what they said they should do outside that situation but that maturity of moral thought should predict to maturity of moral action.
> (Kohlberg 1981:p185)

He does however progress to making a rather stronger claim (1981:p189), when he states that virtue is knowledge of the good and that they who know good will choose good ('good', in Kohlberg's definition, is philosophical knowledge, or intuition of the ideal form of the good, rather than acceptance of received opinion or conventional belief).

Kohlberg proposes a clear demarcation between cognition and affect, in that he states that one follows a moral principle within a given situation because one has a cognitive awareness that it correctly defines what *should* be done, rather than because of an abstract affective identification with the principle per se (1981:p188). A moral judgement is neither an expression of, nor description of, an *affective* state, but fulfils a different function, comprising a *cognitive* structure (1981:p136). Kohlberg thus adheres to the modernist view of emotion and rationality as being discrete entities within the individual. This is a perspective which is at variance with the processes which appear to be used by the students within my own study, in whom the relationship between cognition and affect appears to be symbiotic, rather than consisting of two discrete entities.

Kohlberg follows his argument that knowledge of the good is philosophical knowledge, by proposing that the teaching of virtue involves asking questions and pointing the way, as opposed to providing answers. The social environment, and the institutions contained therein, may provide the role-taking opportunities which he considers to be the prerequisite for moral development (1981:p144, p147). Kohlberg proposes that the means by which moral educators may avoid indoctrination of their students is by stimulation of the students' critical faculties, a process which will in turn enhance their moral development (1981:pxv). Kohlberg proposes that :

> The sequence [ie of developmental stages and levels] provides us with a concept of moral development that can be stimulated by education without indoctrination and yet that helps to move student judgment towards more adequate principles. The way to stimulate stage growth is to pose real or hypothetical dilemmas to students in such a way as to arouse disagreement and uncertainty as to what is right.
> (Kohlberg 1981:p27)[8]

Facilitation of moral development is also possible because, "exposure to others more mature than ourselves helps stimulate maturity in our own value process" (1981:14). Kohlberg cites the work of Blatt and Kohlberg (1975) to substantiate this latter claim, the findings from whose study indicate that some of the students

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[8]That this could be viewed as indoctrination of students with the values of a western, liberal education is unacknowledged.

progressed to a higher stage of moral reasoning following interaction with others at a higher level of development.

Kohlberg's empirical studies

Kohlberg undertook a longitudinal study over a 20 year period, with the purpose of studying moral judgement and character. The core group of participants comprised seventy-five males, interviewed at three-year intervals commencing in their early adolescence. They were provided with hypothetical ethical dilemmas (identified and developed as such by the researchers) and asked to provide descriptions and detailed explication of the action which they considered to be appropriate. The data were then analysed in order to determine the stage and level of moral reasoning demonstrated by the participants. Data were supplemented by a series of studies of moral development in other, non-Western, cultures (Bar-Yam, Kohlberg and Naame 1980) and it was these findings that gave rise to Kohlberg's claim that, whilst responses to dilemmas differed between cultures in relation to their substantive detail, the underpinning stages and ethical principles were nonetheless clearly identifiable as cross-cultural entities and that the stages and levels of moral development may, in his view, be described as universal (1981:pll5-ll6). He asserts that his studies suggest that the same basic ways of moral valuation are found in every culture, develop in the same invariant order and that no important differences are found in the development of moral thinking between those of differing religious beliefs and faiths (1981: pl23). His defence of this position is as follows:

> I do not claim that the structural-developmental theory is culturally universal in the sense of being grounded in, and acceptable to, all cultures. Like the enterprise of moral philosophy itself, the theory springs from Western liberal thought. Therefore, my claim is not that the theory is culturally universal but that basic moral principles are universal.

> I claim that those who attain stage 5 (or 6) in any culture attempt to formulate universalisable principles and that the principles they formulate are recognisably similar from one culture to the next.
> (Kohlberg 1981: p98)

The basic hierarchical structure of the moral stages are primarily reflections of developmental stages in the individual's ability for moral thought at differing conceptual levels. Although all individuals will progress through the same order

or sequence, the rate at which this occurs is variable, as is the end point, ie some individuals will attain Stage 4, whereas a minority may progress to Stage 5 or 6 (1981:p123-4). (It is perhaps noteworthy that this minority appears to contain a disproportionately large number of moral philosophers.)

Kohlberg asserts that his findings led him to conclude that, whilst there are differences in fundamental moral principles between individuals or between groups, these are reflections of the differences in the Stage which they have attained. The Stages, and the motivating principles inherent within each, are, however, culturally universal and are interpretations of categories that are universal (1981:p127).

Kohlberg does not, however, propose that his theory is set within a tablet of stone, but rather that:

> Our theoretical delineation of principles of justice and their growth is not a final dogmatic conclusion; it is reshaped by continuing advances in social science research and in moral philosophy. Here again, we must keep separate the claim of universality and adequacy of moral principles from the universality and adequacy of our own moral theory, which is open to revision. (Kohlberg 1981:p99)

It is of interest that the foregoing comment is a rather more tentative claim than some of Kohlberg's critics, or acolytes, suggest.

It was as a result of the findings of his studies that Kohlberg felt able to provide the definition of stages and their summarisation (1981: Appendix: p409-412). Within Kohlberg's model, moral reasoning is distinguished by three major levels of attainment:

- Level A: Preconventional
- Level B: Conventional
- Level C: Postconventional and Principled.

Subsumed under each of these levels are two Stages. Kohlberg later added another Level, designated B/C, which is transitional between postconventional and principled reasoning, and which he inserted in order to account for the seeming regression which some individuals appear to undergo within the process. (Some

participants attain Level C in one interview and, at a later date, appear to have 'regressed' to Level B in some aspects of their moral reasoning.)

Kohlberg argues that psychological development theory provides an appropriate explanation as to why the moral ideas held at the later levels, which supplant those held earlier, indicate progress.   That Levels B and C are 'higher' is because (in his view) they hold greater adequacy in the resolution of moral problems (1981:p131). Kohlberg argues that his own research findings and those of Rest (1973) indicate that participants are only able to comprehend argument at one level above that which they have personally attained. Progression through stages and levels is thus sequential, although Kohlberg emphasises that he does not consider that 'later' equates with 'better' because, were this so, it would follow that senescence and death would be designated as 'best' (1981:p.xi).[9] He reiterates this point later (1981:p132), in saying that the fact that the stages constitute an order of cognitive difficulty and inclusiveness does not indicate an order of moral adequacy and he uses Kant and Mill as an example, by stating that the greater complexity of the moral theory of the former does not of necessity render it of greater superiority to the more readily understood concepts of the latter.

Kohlberg does however argue that, as the core of each stage of moral reasoning and judgement is the conception of justice, the 'higher' stages, comprising more mature and highly developed powers of moral reasoning, are 'better' fitted for the resolution of justice problems (1981:pxiv). Thus, although Kohlberg avows that cognitive 'superiority' does not equate with moral 'superiority', his identification of the former with the ability to provide more adequate responses to moral questions than the latter implies that the former should hold sway as being arbiter of moral judgement. Prolonged deference to those who possess Level 5 and 6 reasoning ability is likely to lead to their acquisition of moral superiority by virtue of their cognitive superiority.[10] It is difficult, then, to see how the differentiation which Kohlberg makes between cognitive and moral 'superiority' is sustainable, let alone as simple as his sanguine assertion suggests.

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[9]Kohlberg's assertion that cognitive superiority does not equate to moral superiority is one that is not usually acknowledged by his critics.
[10]This assumes, of course, that one accepts Kohlberg's assertion that cognition and morality are discrete entities. I shall argue, with reference to the data from my own study, that they are not but are, rather, interlinked and, indeed, interdependent.

Hierarchical integration is also a feature of Kohlberg's staging system, ie attainment of a 'higher' stage includes integration and reconstruction of 'lower' stage material, although Kohlberg states that his findings indicate that an individual will demonstrate a preference for the highest stage of development available to her/him (1981:p136-7). Kohlberg additionally presumes (1981:p146) that movement to a higher stage entails internal cognitive reorganisation, rather than a straightforward addition of more difficult content onto extant material.

In relation to Kohlberg's assertion that all mental events comprise both cognitive and affective aspects, and that each operates as a discrete entity, he identifies that an individual who has attained one cognitive stage may, on occasion, behave in accordance with a different[11] moral stage of development, one suggested reason being self-interest (1981:p138-9).

Within the **Preconventional Level** (A), it is the case that, during the first stage, *Punishment and Obedience*, individuals consider that 'right' entails literal obedience to rules and authority, avoiding punishment and avoidance of causing physical harm. Actions are judged in terms of physical, rather than psychological, consequences, recognition of the interests of others is absent and the perspective of authority is identified with one's own. Within the second stage, that of *Individual Instrumental Purpose and Exchange*, there is recognition that one's own needs are separable from those of others and from authority and that right action consists in resolution of conflicts by concrete (instrumental) means.

The **Conventional Level** is comprised of the third and fourth stages. The former, *Mutual Interpersonal Expectations, Relationships and Conformity*, involves living up to societal expectations of 'good behaviour', for example being loyal and trustworthy, respectful and grateful. The rationale provided for this behaviour is underpinned by a concrete interpretation of the 'Golden Rule', ie doing unto others as you would wish that they do unto you. Mutuality takes precedence over individuality. The fourth stage, the individual's aim in which is *Social System and Conscience Maintenance*, entails fulfilment of societal obligations with which one

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[11]By necessity this will be lower, ie it is not possible, in Kohlberg's account, for an individual to attain a moral developmental stage above that of cognitive development.

has agreed, explicitly or implicitly, to comply. Maintenance of the social order is the rationale and the substantive detail of right action is answerable by questioning what the consequences would be if everyone behaved in the way in which the individual intends, ie behaviour of the individual is viewed within the context of the system as a whole.

Kohlberg maintains that, in every society that he studied, Stage 4 was the most frequent mode of moral judgement found in adult males (1981:p151) and that only 25% of the study population were found to operate at a higher level.

The **Transitional Level**, defined as Stage 4.5, is one in which conscience and, consequently, right action are viewed as subjective, emotion-driven, arbitrary and relative. No universal principle underpins moral thought or action. Kohlberg views this seeming regression as a relativism which is, "...the disease of which it is the cure" (1981:p130), in that any questioning of conventional morality presupposes (according to Kohlberg) an intuition of the existence of non-arbitrary principles.

Kohlberg claims that, as judgements and actions within the Conventional Level are contextual, rather than universal, they lead to inconsistencies and contradictions, whereas principled morality is directed to the resolution of moral conflicts in a stable and consistent fashion, ie it has the capacity to define what is right for any individual within any situation (1981:pp135-136).

It is, of course, arguable that, whilst identification of universal principles may seem desirable to some, such hankering for certainty amongst the complexities and uncertainties of the human condition is an unattainable goal and comprises what Noddings (1984:p3, p159) terms "romantic rationalism". It is also arguable that the ability to distance oneself from the contextual considerations which are an unavoidable sine qua non of everyday life for the majority of individuals, is a luxury only affordable to those with sufficient resources to devolve responsibility for domestic commitments, for example child care, to others. Another requirement for achievement of such distance may be a working environment removed from any pressing requirement to translate theory into practice and in which most interaction occurs between individuals from similar socio-economic and educational backgrounds. It may thus thrive more readily within some occupational groups than others.

For the nurses within my study, it was an increased awareness of context, and its centrality to the scheme of things, that permeated their development during their preparation for practice. Indeed, 'providing care in context' emerged as being the core category, and basic social process, for the students in their designation of care quality as being satisfactory, or otherwise. Some students stated that, prior to becoming involved in care within practice placement settings, they had felt more able to make unequivocal all-encompassing statements about right and wrong. As they gained increasing information about the substantive circumstances in which individuals were placed, the students became less able to opt for selection of universal principles and, indeed, whilst this created uncertainty and discomfort, none appeared to doubt that it was part of the territory when it came to making moral judgements in healthcare settings. Allowance for the specifics of each situation facilitated, in their view, better decision-making, rather than resulting in anarchy.

The fifth stage, contained within the **Postconventional and Principled Level**, is that of *Prior Rights and Social Contract or Utility*. This comprises awareness that, whilst the values and rules which are 'relative' to one's particular group should normally be upheld, these may be superseded by those which are deemed 'non-relative' ie universal, for example life and freedom. The overall concern in moral judgement and action at this stage is attainment of the greatest benefit for the greatest number and entails a rational individual awareness of values and rights which exist prior to one's personal social attachments and contracts. Kohlberg identifies that problems may arise for the individual in instances in which there is a conflict between the moral and legal point of view, but does not acknowledge the possibility of conflict between personal attachments and the abstract values and rights which should (in his theory) be accorded precedence.

Stage 6, that of *Universal Ethical Principles*, equates right judgement and right action with the use of universal ethical principles, by which all humanity should be bound. These principles are those of justice, which Kohlberg states comprises equality of human rights and respect for the dignity of human beings as individuals (ie to be treated as ends in themselves, not as utilisable means to an end determined by another). Adherence to the laws and social agreements which are founded upon such principles is unproblematic, but in any instance in which a law violates a principle, one should act in accordance with the latter.

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Kohlberg's findings indicated that Stage 6 thinking is attained by a small minority and he notes that both Stages 5 and 6 are absent in preliterate or semi-literate village cultures, which he suggests supports a mild degree of social evolutionism.[12] He cites Westermark's (1960) suggestion that, as civilisations become increasingly advanced (sic), this entails an increase in the size of one's immediate social unit, and replacement of the idea of tribe by that of nationhood. It may also indicate that the use of principles is problematic when those with the responsibility for decision-making possess intimate knowledge of contextual detail.

Kohlberg uses Socrates, Lincoln, Jefferson, Gandhi and Martin Luther King as examples of those who, by his criteria, have attained Stage 6 moral reasoning. He does however acknowledge that even Stage 6 principles may be somewhat influenced by cultural content and uses the toleration of slavery by Socrates, Lincoln and Jefferson as examples. He also accepts that there may be a tension, or discrepancy, between the public advocacy of, and adherence to, Stage 6 principles and a less rigorous demonstration of these in the private practices of individuals (1981:pl27-8).

Utilisation of Kohlberg's theory by subsequent researchers

The studies carried out by Piaget and Kohlberg utilised hypothetical moral dilemmas (as defined by the researchers). These were presented to participants, who were then asked to describe the action that should be taken and the rationale for their decision. Whereas Piaget aimed to elicit information for specific scoring situations, Kohlberg's approach was more open-ended. The latter's stories were multifactorial and the participants free to explore any aspect; scoring was thus more complex. Rest (1976) points out that different moral judgement tasks assess different aspects of development and that his (Rest 1973) study, in which

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[12]It is of interest that Kohlberg operates from the (unsubstantiated) assumption that 'westernised' societies should constitute the yardstick against which others are measured (and, in this instance, found wanting). It also links with his later suggestion (following publication of Gilligan's work) that, if women are currently at a 'lower' level of moral development than that of men, it may be possible to address this 'deficiency' by according them a greater role in public life ie by providing opportunities for them to learn by example from men.

statements prototypic of different moral judgement stages were presented to participants, indicate that individuals may comprehend, and demonstrate a preference for, statements of a higher stage than that which they spontaneously use. Rest (1976:p203) thus emphasises the importance of identifying the *task* required of the participants in research prior to making any suggestion that an individual possesses, or lacks, a particular concept, or has attained a certain stage of development.

Rest's *Defining Issues Test*

A number of researchers into the moral reasoning of nurses have used Rest's (1974) *Defining Issues Test*, or a modification thereof, as a tool within their own studies. For that reason, I shall provide a brief description of this instrument.

Rest's (1974) *Defining Issues Test* (DIT)[13] was constructed in an attempt to assess individuals' perceptions of crucial moral issues in a given situation. Participants are presented with a moral dilemma (as defined by the researchers) and a list of pre-determined definitions of the major issues involved. For each of six scenarios there is a list of twelve identified issues, the participants being asked to rate the importance of each (by five-point Lickert scale) in determination of the action required and to identify the four which they consider the most salient. Rest says that:

> Since each issue statement represents a moral judgment stage, a subject's choices of the most important issues over a number of moral dilemmas are taken as a measure of his [sic] grasp of different stages of moral reasoning. (Rest 1976:p204)

Rest contends that the aim of the DIT is:

> ...to assess moral judgement by an objective format - that is, by using completely standarized stimuli and test conditions and by having the subject respond in terms of ratings or rankings instead of in the free-response mode. (Rest 1976:p205)

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[13]Rest subsequently revised and refined this (Rest et al 1986, 1993), but as Rest (1976) is the information source most frequently cited by those who have used the DIT, it is the explication that I shall use.

That the 'subjects', in any study, are not genetically and experientially cloned and will thus bring to the "standardized stimuli and test conditions" a wide variation in attitudes, values and beliefs (as will the researcher) is not acknowledged, let alone identified as being an impediment in the way of 'objectivity'.

Rest supports his proposed method by stating that:

> ...it is helpful to consider the two basic options in moral judgment assessment: (1) having the subject talk or write about his moral thinking in a free-response mode and then having a scorer use some standardized system to classify the response, (2) presenting the subject with a set of standardized alternatives representing the scoring categories and having the subject rate or rank them. The essential difference is that in the first case the scorer judges how the subject's thinking fits the categories, whereas in the second case the subject in effect decides the fit by indicating the statements that are closest to his own judgment...In order to find out what people actually think without prejudging the case, the free-response method is an essential first step. Research using this kind of interviewing made it possible subsequently to construct the DIT items and to formulate clearly the stage characteristics on which the items are keyed...when the purpose of data collection is no longer to explore new scoring characteristics but to provide assessments of moral judgment development, then the advantages of the free-response method are diminished.
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> In conclusion, information about a person's moral judgment can be elicited by asking a subject to do any of several different tasks: solve hypothetical moral dilemmas, indicate a preference among moral judgment statements, or rank the most important issues in a dilemma."
> (Rest 1976:p205)

Rest emphasises that the selection of a data collection method (from amongst the methods that he identifies) should be driven by the aims of individual studies. He identifies the problem of participant inconsistency, saying that:

> The truth seems to be that people are only partially consistent in the way they make moral judgments from situation to situation, from testing to testing.
> (Rest 1976:p206)

Rest describes these inconsistencies as "performance discrepancies" (1976:p206) and suggests that, "If the stimulus material differs from story to story, however,

something will probably cause variability in the subjects' level of moral judgment" (1976:p207). He concludes from this, firstly, that a single story or test situation cannot be assumed to represent a participant's general moral judgment level of a subject and, secondly, that when comparisons are made between participants, then the same set of test stimuli should be employed under standardised conditions (1976:p207). Whilst I concur with Rest's first conclusion, the second ignores, as earlier (1976:p205), the differing prior life experiences which all participants bring to the research enterprise. Identical test stimuli may thus not be 'identical' to all participants except in theory and the feasibility of 'standardising' conditions is equally questionable, both in relation to interviewer and participant differentials. Similar expectations of standardised responses to an 'identical' stimulus are, however, conveyed by many researchers using this method, one example being Corley and Selig (1992:p387).

Rest argues that the aforementioned "performance discrepancies" and what he refers to as "subject vacillation", may provide reason to question the extant method of designating individuals' moral judgment in terms of stage types. He points out that it is rare for participants to provide responses that are exclusively located at one stage (1976:p207), but that developmental advance is not an abrupt movement from one stage to another but, rather, entails the existence of some inter-relationships and overlap between stages (1976:p208).

In relation to validation of a measure of moral judgement, Rest says that:

> The purpose of moral judgment assessment is not simply to collect verbal statements in order to predict observable behavior, but rather to use verbal information as indicators of inner thought patterns and processes. A moral judgment measure may turn out to have striking relationships with some observed behavior, but the validation of a moral judgment measure is not based simply on this correlation. The referent of the measure is something inside the head, as in the case with other psychological constructs...Validating a measure of moral judgment therefore is a multi-faceted procedure and a matter of determining the degree to which a measure produces data trends conforming to a set of theoretical expectations.
> (Rest 1976:p213)

That the values and assumptions of the researchers are integral to the entire enterprise is evident, but unacknowledged. One example of this is the comment which Rest makes in relation to an attitude test (the *Law and Order Test*) utilised

by Rest (1974). He describes it as comprising fifteen controversial public policy statements, a five-point Likert scale signifying the participants' agreement or disagreement. Rest goes on to say that:

> Responses which advocated giving excessive [sic] powers to authorities or supporting the existing social system at the disproportionate [sic] expense of civil rights or individual welfare were keyed as law and order.
> (Rest 1976:p217).

That the researchers' stance upon such issues is taken as the norm, in the definition of what constitutes "excessive power", or "disproportionate expense of civil rights or individual welfare", is unacknowledged, let alone addressed as being a factor which permeates the entirety of the research process and outcome. The conception of the researchers as 'expert', and the concomitant assumption that any departure from their perspective constitutes "inconsistencies" and "performance discrepancies" (for example, 1974:p206), permeates the text.

A situation similar to the above occurs when researchers claim post-test gains in participants' moral reasoning and judgement, subsequent to their completion of a course in the subject (taught by people of the same mindset as the researchers). Rest (1976:p218), for example, cites a study (Panowitsch 1975), which found that post-test DIT scores for a group of students undertaking an ethics course were significantly higher than those for the control group, who had studied a different subject. It may be argued here that 'schooling' individuals in methods of moral reasoning deemed acceptable, and subsequent grading of them according to this status quo, is self-referential.[14]

Similarly, Krawczyk (1997:p61) used the DIT within her study to measure the DIT scores of groups of student nurses (total n = 180). Some of the participants undertook an ethics course taught by a professor of ethics, others a course in which ethical issues were integrated into all nursing theory courses and a third group received no formal ethical input. The findings were that the first group demonstrated the highest scores in the DIT. Krawczyk (1997:p57) concluded from this that undertaking a formalised ethics course which provides group

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[14]See also McAlpine et al (1997).

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participation and a decision-making element significantly facilitates nursing students' development of moral judgement.

In later work, Rest (1986) proposed a four-stage model of the processes required for moral action. The first, moral sensitivity, results from an individual's cognitive awareness that a moral problem exists, ie a situation in which rights, duties, values or principles conflict. The second stage, moral reasoning, comprises an evaluation of the foregoing, in order to determine the action which should be taken. This is followed by moral commitment, in which one course of action is deemed morally correct and the final stage is its implementation (1986:p3-18). Rest states that, for successful completion of the final stage, possession by the individual of the psychological attributes and interpersonal abilities (such as communication skills) is necessary. Impediments, such as organisational constraints, are not discussed, although Crisham (1981), a description of whose work follows, does place emphasis upon their importance.

As stated earlier, many researchers into the moral reasoning of nurses have utilised Rest's *Defining Issues Test*, or a modification of this. I shall outline some of this work and identify themes which are recurrent, both in relation to the findings from such studies, and in relation to the premises and assumptions upon which they are based.

Use of the *Defining Issues Test* (DIT), or modification thereof, in relation to nursing

Crisham (1981) identifies the lack of sytematic study into the relationship between moral judgements made in the abstract and actual decision-making in nursing practice. Her own research investigated the differences between nurses' responses to hypothetical moral dilemmas (using Rest's 1974 *Defining Issues Test*) and their responses to substantive nursing practice dilemmas. She developed a *Nursing Dilemmas Test* (NDT) by means of interviewing 130 staff nurses and asking them to describe a nursing dilemma which they had experienced. A dilemma was classified as recurrent if a minimum of five nurses described the same problem: twenty-one dilemmas were thus identified, of which six were selected for use (the criteria for this selection were not explicated). Each dilemma in the NDT is accorded three tasks for completion by participants, the first of which is identification of the desired nursing action. Nurses are then asked to rank six

moral and practical considerations in order of importance: these were devised by the researcher, each being identified as corresponding to a different stage of moral reasoning. The final question asks participants to indicate their degree of personal familiarity with a similar dilemma (1981:p105-107). The participants were also asked to complete Rest's (1974) DIT.

The DIT and NDT were completed by a total of 225 nurses (Crisham 1981), with a range of differing educational qualifications. Overall, the findings indicated that nurses with the greatest amount of formal educational attainment and also those who indicated familiarity, in their own practice, with the dilemmas presented in the NDT, were the most likely to identify considerations associated with principled moral thinking (Crisham:p104, p110). The findings indicated a lower positive correlation than anticipated by Crisham, between the participants' moral judgement about hypothetical dilemmas and their moral judgement about real-life nursing dilemmas (1981:p108-109). Crisham suggests that this was caused by the participants' awareness of the organisational constraints upon practice which operate within clinical settings (1981:p110).

In the light of these findings, Crisham indicates the need for identification of situational pressures, conflicting moral claims and the context within which nursing practice dilemmas occur, in order to advance knowledge of how moral judgements are made (1981:p110). This is of particular interest in relation to the data from the students within my own study, as one outcome of the students' increasing access over time to what one of them termed 'the bigger picture' was an acknowledgement of the impact of organisational constraints and contextual considerations. Whilst passing references were made to these in early interviews, it was in the students' final interview prior to completion of their programme that this recognition was accorded the greatest status, being spoken of in a much more personal way, as students by then recognised the effect that these considerations might have upon their own ability to practice as registered nurses in the foreseeable future.

Although identification of situational constraints within clinical practice is widely recognised within the nursing literature, and will be explored in some detail within Chapter Four, Crisham's recognition is relatively rare within the moral reasoning literature based upon the theories of Kohlberg and Rest.

Duckett et al (1992)[15] published a paper which aimed to clarify theoretical and measurement issues related to moral reasoning. They provide a critical review of the research literature related to the moral reasoning of nursing students, including studies which utilised the DIT. This review identifies the need for greater rigour in studies and the need for accuracy in the interpretation and reporting of moral reasoning scores. Overall, however, findings from such studies indicate that the moral reasoning of nurses (as with other groups) tends to increase with formal education (1992:p324).

Corley and Sellig (1992) distributed vignettes and requested participants to identify issues that they deemed to be of relevance and to rank these. Replies were then subject to content analysis and coded (1992:p384). Interestingly, the vignette in which the fewest respondents selected issues that the researchers had identified as representative of principled thinking, was that which related to the reporting of medication errors. Several of the participants, subsequently interviewed, attributed this to the likelihood that many nurses had made medication errors, that these represented a threat to their employment status, and that they had failed to report them. This attribution would appear to support Crisham's (1981:p110) comment about the effect of organisational constraints upon nursing practice. If practitioners are aware that admission to making a medication error will result in disciplinary action being taken by management, then they may be less likely to report such errors.

Organisational constraints were a factor noted by students within my own study, some of whom failed to take more than very limited action when they encountered what they considered to be bad practice. Their reasons were that they felt powerless to effect change and also felt inhibited about vocalising concerns because of their requirement to gain a satisfactory practice placement assessment.

Corley and Sellig (1992) report that the nurses who were interviewed suggested that the medication error vignette be deleted from future studies, which the authors identify as an interesting approach to dealing with discomfort. Corley and Selig concede that the findings which they review from studies using the NDT are inconsistent, as are their own findings, and they identify the bias of the NDT towards justice reasoning as being a major limitation. They conclude that, if

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[15]Crisham and Rest were amongst the co-authors of this paper.

further testing of the modified NDT does not yield greater reliability, then a new approach to assessment of nurses' moral reasoning is required.

Ketefian (1981a) had used Rest's (1974) *Defining Issues Test* in a study of the moral judgement of practising nurses, but subsequently (Ketefian (1981b) developed his own measurement tool, *Judgments About Nursing Decisions* (JAND), which uses six scenarios depicting nurses in ethical dilemmas. These dilemmas were approved by individuals considered to be nurse experts, in order to verify that the scenarios were feasible in practice. Each scenario is followed by a list of six or seven nursing actions, each of which participants are required to tick 'yes' or 'no', firstly in a column which asks whether they think that the nurse experiencing the dilemma *should*, or *should not*, engage in that action. They are then asked to complete a second column, which asks whether they think that the nurse is *likely* to engage in the action. In Ketefian's (1985) study, the JAND was used, for example, to study the relationship between professional and bureaucratic role conceptions and moral behaviour amongst nurses. Findings indicated that professional role conflict has an adverse effect on moral behaviour. So, even in completion of tests, contextual problems will increase the complexity of responses and demonstrate a 'lower' standard of 'moral behaviour' than will problems which are abstracted from the reality of practice. Ketefian's measurement tool has been utilised by a number of nurse researchers, in the belief that it more accurately reflects the moral reasoning of nurses than do tools, such as Rest's (1974) DIT, which use abstractions unrelated to nursing practice.

Dierckx de Casterle et al (1996, 1997) modified Kohlberg's theory of moral development by adding a care perspective. The overall purpose of their (n=2624) study was to investigate the relationship between education (with specific reference to moral reasoning ability) and ethical behaviour of nursing students. The latter is defined as being that which is, "...based on their own decisions, their personal value judgments, and their commitment to promote patient welfare." (1996:p336)

Dierckx de Casterle et al developed what they termed the *Ethical Behavior Test* (EBT), which was based upon Rest's (1974) DIT and Crisham's (1981) NDT. It comprises five situations in which nurses are confronted with ethical dilemmas considered to be commonly-encountered in practice. Participants are asked to select the most desirable of two proposed solutions and are then asked to value

and rank five arguments supportive of their choice, from within a list, in order of importance. A third question provides a short description of five situations which may impede implementation of the decision and participants are similarly requested to rank these.

Findings indicated that, overall, nursing students can be located within Kohlberg's fourth stage of moral reasoning (ie conventional level). There was deemed to be a significant relationship between the scores of ethical behaviour and the students' level of educational attainment. Female participants scored slightly, but significantly, higher in ethical reasoning than did males. There was a small, but positive, correlation between ethical reasoning and the implementation of ethical decisions, but females appeared to have a greater susceptibility to influence by contextual factors when implementing ethical decisions than did males.

One problem with Dierckx de Casterle et al's studies is that, despite the initial assertion that the relationship between moral reasoning and ethical behaviour would be explored, testing of the latter was carried out by means of the EBT, which comprises self-reporting by participants upon their actions in relation to a hypothetical dilemma. It appears tenuous to correlate what participants *say* that they would do in a hypothetical situation to what they may *do* in reality. A single-sentence acknowledgement of this point is provided (1997:p24).

McAlpine et al (1997) similarly identify that the major tools used to measure the moral reasoning of nurses have yielded inconsistent results and propose that the lack of acknowledgement of the participants' personal conception of 'moral' issues and consequent thinking, is problematic. They therefore developed and tested a new measure, the *Ethical Reasoning Tool* (ERT), which aimed to assess nurses' cognitive reasoning in response to an ethical practice dilemma. Their secondary aim was to assess, by means of a pre and post test, the predominant level of ethical thinking demonstrated by post-registration students, who were practising nurses undertaking a study unit on ethics. A dilemma was constructed by the researchers on the grounds of its probable familiarity to the study's participants. Prior to commencement of the study unit, and again following its completion, participants were asked to identify significant ethical issues raised by the case study, state what action they deemed necessary and provide a rationale from an ethical perspective. Subsequent to the post-test, pre-test responses were returned to the participants, who were asked to provide reflective comment upon

these. (Information about the precise purpose of the study was withheld until completion of the post-test.) Responses were analysed and categorised as belonging to one of three 'professional response levels': *Traditional* (ie intuitive, conventional), *Traditional/Reflective* and *Reflective*. Exemplar behaviours found within each level were outlined, using eight components of ethical thinking (1997:ppll53-ll54).

Findings from the study indicate statistically significant changes between pre and post test results in the participants' ability to recognise ethical issues, use an ethical framework and also employ their own personal values to direct decision-making. The authors conclude that the ERT demonstrates a promising way to measure professional responses to ethical issues. They also propose that:

> ... if nurse educators have a means of evaluating the ethical reasoning of students prior to an ethics unit, they are able to shape educational strategies to mitigate apparent areas of cognitive insufficiency...[also] use of such a tool will allow nurse educators to obtain evidence upon which to evaluate the effectiveness of nursing ethics study units.
> (McAlpine et al 1997:pll59)

It may be argued that the findings of the study indicate only that the content of the study unit had been absorbed by the students, at least to the point of their ability to relate it to a scenario.

Summary: the influence of Kohlberg

The preceding section reviewed a selection from studies which have used Kohlberg's model of moral reasoning as a template from which to develop research tools. Within my own study, the aim was to explore the students' perspectives in relation to the patient/client care that they encountered and the factors that led them to designate care as satisfactory or otherwise. I did not approach the study, nor analyse the data, with a view to attributing the students' comments to a particular 'level' of moral development, nor with the intention of identifying the extent to which their comments within interview discussions translated, or did not, into practice. It was, however, of interest that, although the students had received theoretical input in relational to ethical and moral development theories, none used this material in order to support, or refute, their

own decision-making processes. (This absence of comment does not, of course, indicate that the students were not influenced by this theoretical input, simply that they did not explicate it in interview discussion.) I had not suggested that they do so, as I wished the students to make their own decisions as to material which they deemed relevant, or otherwise, to the discussions. They did, on quite a number of occasions, refer to their theoretical input, but this usually related to concepts of what the university identified as 'good practice', such as an holistic approach to patient care. As these references to university input were sometimes delivered with irony, if not mockery, they did not appear to constitute a 'researcher-pleasing' strategy.

Whilst it would no doubt have been possible for me to have allocated student responses to corresponding 'levels' of moral reasoning, it appeared to me to be a rather artificial, arid and self-referential exercise, which would have reduced to students' complex processes of reasoning to a series of simplified, and possibly inaccurate, 'boxable' responses.

My reason for allocation of so much space to the work of Kohlberg and his adherents has been due to its enduring influence over time. As stated within Chapter One, this influential body of work did not appear to connect easily to the experiences of myself or my colleagues, either as a nurse or as a lecturer listening to students' accounts of decision-making within practice placement settings. It seemed important, therefore, to evaluate whether it was appropriate to analyse the responses of the student nurses in my own study in accordance with Kohlberg's theory. Having decided that this was a stultifying approach to the data, it was then necessary to identify and explore alternative theoretical perspectives, in order to ascertain their correspondence with the students' perspectives.

Alternative perspectives to that of Kohlberg

Hoffman (1987) rejects the modernist assumption that morality derives from universal, abstract principles. He supports this by reference to the empirical finding that children display a tendency to empathise with others, prior to development of the ability to verbalise moral principles and that this indicates that its initial base is founded within substantive situations. Hoffman argues that, once individuals develop the ability to articulate their feelings and behaviours, both their

internal moral narratives and those which they produce for others, comprise an interactive sequence of empathy and cognition.

Whilst an empathic response to patients was evident in most of the students' responses in my own study, it was most clearly explicated by Euan, who spoke in each interview of his attempts to think how he would feel, were he the patient, and who advocated what he termed, a 'do-as-you-would-be-done-by', approach. The interplay between empathy and cognition was evident in Sheila's account (Interview 25:pl2-l3) of a family who made the decision to place their severely mentally and physically challenged child into care. The relationship between empathy and cognition will be further discussed in the chapter on the study's findings.

Bruner (1986) proposes two distinct modes of thought. Propositional thought relates to that involved in the use of logical argument in support of abstract principles, or truths, whereas narrative thought relies upon the specifics of an actual occurrence or experience in order to demonstrate validity. To the extent that individuals interpret moral issues in the context of a personal narrative, as opposed to semantic formulation of the problem, there is a qualitative divergence from Kohlberg's model and this appeared to be more in accordance with the findings from my own study.

Vitz (1990) contends that narratives (written or verbal) have a greater likelihood of capturing the imagination, than do abstract propositional arguments and that they may thus be of greater use than the latter in the facilitation of moral development (p7l6). Vitz concludes that the existence of a single theoretical model of morality with universal applicability and relevance is unlikely and that it may be better to acknowledge this than to search for a non-existent grail (p7l8). This comment may be interpreted as support for a multiplicity of moral voices, rather than the modernist vision of one voice, which is privileged to the exclusion or negation of all others.

White (l98l:pl60-l68) proposes that altruistic motives emerge and grow within a matrix of other motives, ie humanitarian feeling does not grow in isolation. Usually socialisation entails that altruistic behaviour is embarked upon as a duty prior to its being an expression of intrinsic concern and, indeed, the former motivation may continue into adulthood. During childhood, empathic feeling is

directed towards those with whom we have direct contact, whereas during adolescence there is often an abrupt expansion of empathy. White points out that the process of empathy does not always entail identification with the good, in that we may empathise with people who engage in what might be viewed as negative behaviour.

Empathy is not automatic, in that tension may exist between a concern for the well-being of others and for one's own self-interest. The degree of competition between the two may be affected to a considerable extent by the surrounding social system and White (1981:p168) suggests that it is a truism that a humanitarian environment is more likely to facilitate humanitarian behaviour. This suggestion is supported by the data from my own study, in which 'cycles' of behavioural response by the staff appeared to be triggered, and subsequently reinforced, by the care environment. This was most clearly identified by Alan (Interview 17:pp3-5), in his description of two care of the elderly wards within the same hospital, in which the physical environment and funding allocation was similar, but in which the approaches to patient care were markedly different. The area in which the care was what Alan described as 'good' was one in which the care was individualised and in which the staff appeared motivated to provide this, whereas the area in which care was perceived as 'poor' was one in which the staff appeared to treat patients as objects, rather than individuals, and which was short-staffed due to recruitment difficulties. The factors which facilitate, or inhibit, a humanitarian care environment will be discussed in detail within Chapter Four. It was also a finding from my study that other external constraints upon the students, such as financial worries and the consequent requirement to find paid employment in addition to their coursework, had the capacity to interfere with their ability to provide care to the standard that they considered desirable.

Development as recursive

Perry (1981) argues that, in any theory of development which is 'position' or 'stage' dependent, one may obtain a snapshot of an individual at set points in time, positions by definition being static, but that, as development is fluid, the transition between one position and another may be lost. Perry suggests the possibility that the concept of development is, in reality, comprised entirely of transition and that any identified stages are merely resting points within this. (An alternative, or additional, explanation is that stages are the points at which individual is able to

identify concrete examples of the changes which development has wrought.)
Perry's (1981) initial study was conducted in the late nineteen fifties and early
sixties by means of unstructured interviews with student volunteers, in order to
obtain a longitudinal data set. Students were initially interviewed upon completion
of their freshman year and annually thereafter.

The diversity of data exceeded Perry's expectations but, although he originally
attributed this variation to differing personality types, he came to see that the
reinterpretations of the students' lives appeared to fall into a logical progression,
with development occurring in response to challenges to their existing perceptions
of the world. When their extant worldview proved inadequate to account for
increasing complexity, the students adapted their thinking to a position which
helped to make sense of the new experience, although this concomitantly provided
a threat (1981:p78).

Perry, in the light of his findings, developed a model of cognitive and ethical
development (1981:pp79-80), suggesting that the process is recursive rather than
linear and that representation may be more adequately visualised as a helix,
possibly with an ever-expanding radius, as opposed to conceptualised as linear, or
circular (1981:p97). Students, in his model, commence with a dualistic perspective.
Dualism is defined as being the division of meaning into two realms, for example
Good versus Bad, Right versus Wrong, Success versus Failure. This was
modified by the students in the light of experience and subsequently superseded by
the discovery of relativism. Relativism acknowledged the existence and validity of
diverse opinions, values and judgements, which students evaluated in order to
identify the most appropriate within a given context, but it proved problematic
when it came to commitment to one particular viewpoint on the grounds of
greater moral adequacy than others. Students moved from this point to one in
which they developed commitments in relativism. These commitments provided
structure for the relativistic world and enabled students to make important
life-choices and decisions, whilst retaining their awareness of relativism.

Perry's (1981) findings link with the data from my own study, in which Euan and
Jane vividly describe how, over time, they came to realise that a patient is not
always 'the goody' simply by virtue of being 'a patient', but possesses a
highly-individualised combination of what are deemed to be 'positive' and
'negative' qualities. Awareness of this was rather a shock initially to some

students and its accommodation took time and proved challenging. Similarly, in Sheila's and Anne's final interviews (Interviews 25 and 29), they describe how their previously rather 'black and white' views were challenged by experience and subject to modification, a process accompanied by some degree of <u>angst</u>. None of the students within my study spoke of the bewilderment which Perry suggests may accompany increased awareness of relativism, nor did they demonstrate adoption of a purely relativist approach but, rather, by the time of the final interview they appeared to have acquired the commitment in relativism of which Perry speaks.

Perry (1981:p78) emphasises that each Position both includes and transcends those preceding it, this being the factor that marks the movement as being developmental, rather than being due solely to a change in view within the same overall position. There is a movement over time from 'holding' meaning to 'making' meaning, ie the latter involves construction of an individual's own viewpoint in the light of their personal, unique, experiences. This process entails an inner dialectic, which requires resolution of the tensions between opposing lines of thought. Perry (1981:p87) at this point draws attention to the irony, which Kohlberg, in his assertion that indoctrination may be avoided by a liberal education, fails to acknowledge, that the ability for 'meta-thought' is learnt because it is the way in which liberal educationists wish students to think.

Perry's studies identify that development entails threat as well as opportunity and that this may, if the threat is perceived as being too difficult to handle, lead to retreat into an earlier position (1981:p80). Vulnerability is likely to remain a feature of the later developmental positions, due to the lack of certainties and the awareness that one must learn to exist in their absence. There are problems for some students, in their experience of a grieving process consequent upon relinquishment of their previous, ontologically secure, position and this should be acknowledged by educators. Within my own study, the students recognised that, as their experience increased, it became increasingly difficult to determine the precise factors which constituted 'good care', as these were context-dependent, although their ability to recognise 'bad care' remained fairly clear-cut over time. Despite the fact that acknowledgement of, and accommodation for, this complexity rendered life at times problematic, it was viewed by the students as a positive process, which would improve the quality of patient care which they were able to deliver.

Perry proposed that the term 'cognitive style' is appropriate when referring to the relatively stable, preferred tactics utilised by an individual across a wide range of situations, whereas 'cognitive strategy' is a suitable description of the tactics selected from the range of options available in a substantive context. Strategy, then, takes precedence over style although the two are, in most instances, compatible.

In Perry's later studies, which were carried out during the seventies, his finding was that Harvard freshmen (sic) were at a developmental position ahead of those in his earlier study and that their commitments appeared to be career-oriented.[16] Nonetheless, their overall progression was congruent with that of the earlier group and Perry suggests that the course of cognitive and ethical development which he outline appears to be a constant phenomenon within a pluralistic culture. These comments are, of course, open to the argument that findings obtained from 'Ivy League' students may be phenomena attributable only to a particular sub-group within a pluralistic culture, in addition to being time and context-dependent. Perry does not address these points.

Interestingly, following publication of Perry's findings, some researchers proposed the formulation of a rating scale, in order to facilitate the categorisation of individuals' developmental attainment. Perry was prompted into such a formulation, in order to demonstrate that it would prove inadequate to the task, and was successful in this (1981:p98-99). (The inability of rating scales to encapsulate the complexities of developmental processes was identified earlier in this literature review, in discussion of the research methods used by Kohlberg and his adherents.)

Perry asserts that it is only up to a certain developmental point that individuals are undifferentiated from the opinions which they hold and that, presumably, thereafter the person and their opinions may be viewed as separable (1981:85). This concurs with Kohlberg's theoretical perspective, but is contrary to that of Gilligan, Hekman and Manning, who argue that, throughout life, one's opinions, values and moral judgements are an integral part of the totality of the individual.

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[16]Perry suggests that the intervening economic downturn and the Vietnam war may have been influential in production of this apparent difference.

Perry concluded that the implications for educators are that, in order to facilitate student progression from dualism to commitment in relativism, it is necessary to teach dialectically. This method will introduce students,

> ...not only to the orderly certainties of our subject matter but to its unresolved dilemmas. This is an art that requires timing, learned only by paying close attention to students' ways of making meaning.
> (Perry 1981:p109)

Kaplan (1983), like Perry (1981), distinguishes between the notion of 'development', with its denotion of cognitive or affective progression between one point in time and another and 'change over time', which may be present in the absence of progression.[17] Kaplan admits that the notion of development implies a priori values, assumptions and presupposition. In relation to those who propose that developmental research *is* objective, Kaplan emphasises that the danger lies, not in the fact that such research is subjective, but in entertaining the possibility that it could be otherwise. A prerequisite for any investigation of moral development is identification of a particular moral phenomenon as a desirable end-point and this, in itself, entails subjective values and assumptions.

The work of Gilligan

Gilligan, who was a student, and later colleague, of Kohlberg at Harvard, came to the conclusion that his approach provided an incomplete picture of the processes of moral reasoning due, in the main, to its androcentricity. Kohlberg's studies were underpinned by the notion of the male experience as being the 'norm', against which both sexes were measured. In the studies upon which his model of moral development was predicated, all 75 participants were male.[18] That his selected sample excluded 50% of the population from the study was not considered relevant, nor worthy of note, indicating an implicit assumption that

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[17]This links with the modernist notion of progression, ie movement and improvement over time, which many writers, (for example Freeman 1993) reject.
[18] Piaget, upon whose work Kohlberg developed his own theories, also used males in his initial studies, although participants were referred to as 'the child', gender identification being considered unnecessary.

measurement of male experience sufficed as the foundation from which to extrapolate generalisable findings. It did not seem to be the case that the experiences of girls and women were acknowledged but ignored but, rather, that any possibility of difference in construction of morality was unacknowledged.

In the (1993) preface to a reprint of her (1982) work, Gilligan says that her purpose has not been to valorize the experience and moral judgements made by women at the expense of men (although there are occasions on which she does appear to do this, for example p16-17) and that her intention has not been to identify whether women and men are essentially different, or who is better than whom. She argues that:

> My questions are about psychological processes and theory, particularly theories in which men's experience stands for all of human experience - theories which eclipse the lives of women and shut out women's voices. (Gilligan 1993:p.xiii)

Gilligan argues, drawing upon the work of Chodorow (1978), that women's socialisation focuses upon issues of connection, rather than separation, and those of responsibility, care and concern, rather than autonomy. This leads women to provide answers to moral dilemmas that are dependent upon the context of substantive situations, and that are focused upon the maintenance of relationships, as opposed to the provision of abstract, universal, principles as their rationale for action. As attainment of the 'higher' stages of Kohlberg's model of moral reasoning is dependent upon the individual's ability to provide just 'principled' reasons for action, girls and women who were studied using his criteria were deemed to have a lower moral reasoning ability and attainment (usually that of Stage 3) than boys and men.

Gilligan's experiences in conducting research using Kohlberg's approach led her to conclude that women speak with a different moral voice to that of men. As it is the male voice which is taken to be the norm, divergence from that is taken to be deviant. Although she has published widely, I shall use *In a Different Voice* (1982, 1993) as the basis for discussion, as it is the most commonly cited by those who base their theoretical perspective and research methods upon her work. Within her book, Gilligan provides excerpts from three of her research studies, using her approach to data collection and her findings in order to illustrate and support her arguments. She states (1993:p3-4) that the goal of her research has been

expansion of the understanding of human development by using the group (ie women) who were omitted in the construction of the hegemonic theories. In doing so, her intention has been to draw attention to what was previously unacknowledged and thereby to generate new theory, with the potential of yielding a more encompassing and comprehensive view of the lives of both the sexes.

Gilligan argues that the theories of moral development previously considered to be sexually neutral in their scientific objectivity (with particular reference to the work of Piaget and Kohlberg) have been found to reflect consistent observation and evaluation bias and she contends that categories of knowledge are human constructions. The standpoint from which the studies of Kohlberg and his colleagues were conducted, despite his assertions that his findings were universalisable, was androcentric, white, intellectual, middle-class and American, although it is the first of these to which she accords prominence in her critique. In Gilligan's view, Kohlberg's studies are flawed because of their assumption of male experience as being the norm, against which all data, irrespective of the gender or provenance of their subjects, are subsequently measured. As Gilligan points out (1993:p18), the paradox here is that the very values that mark females as 'good women' are those which downgrade their moral development in Kohlberg's model. Gilligan argues that, whereas men are socialised into accepting a conception of morality as fairness, thereby entailing a moral development linked to understanding of rights and rules, women's experience of morality as being concerned with care entails that moral development centres on an understanding of responsibility and relationships. Kohlberg's criteria however, identify all such constructions as evidence of moral development at the Conventional Level. If, Gilligan argues, studies commence by looking at women in their own right, without using male experience as the yardstick by which they are judged, a different picture from that depicted in Kohlberg's studies emerges:

> In this conception, the moral problem arises from conflicting responsibilities rather than from competing rights and requires for its resolution a mode of thinking that is contextual and narrative rather than formal and abstract. (Gilligan 1993:p19)

Gilligan's empirical studies

Within Gilligan's book, the findings from her studies are presented, as stated earlier, in the form of excerpts which she uses to illustrate and support her argument that women's definition of the moral domain is centred around concepts of care and responsibility rather than upon rights, rules and principles. Whilst her narrative approach renders her work accessible to a wider audience than academics, it has also resulted in the devaluation of her work by many within the latter group, on the grounds that it is lacking in academic rigour (for one example, see Kerber et al 1986). That Gilligan's approach entailed asking participants to explain how they identify and define moral problems, as opposed to focusing upon responses to pre-determined dilemmas which are then subject to neat categorisation, was also the subject of criticism. A counter-argument is that, whilst asking participants to provide their own definitions may be problematic in any research enterprise, it is no more so than is the mapping of participants' responses onto researcher-selected dilemmas and criteria. Gilligan emphasises that:

> Hypothetical dilemmas, in the abstraction of their presentation, divest moral actors from the history and psychology of their individual lives and separate the moral problem from the social contingencies of its possible occurrence. In doing so, these dilemmas are useful for the distillation and refinement of objective principles of justice and for measuring the formal logic of equality and reciprocity. However, the reconstruction of the dilemma in its contextual particularity allows the understanding of cause and consequences which engages the compassion and tolerance repeatedly noted to distinguish the moral judgements of women. Only when substance is given to the skeletal lives of hypothetical people is it possible to consider the social injustice that their moral problems may reflect and to imagine the individual suffering their occurrence...The proclivity of women to reconstruct hypothetical dilemmas in terms of the real, to request or to supply missing information about the nature of the people and the places where they live, shifts their judgement away from the hierarchical ordering of principles and the formal procedures of decision making. This insistence on the particular signifies an orientation to the dilemma and to moral problems in general that differs from any current developmental stage descriptions.
> (Gilligan 1993:p100-101)

In one of Gilligan's studies 25 college students, randomly selected from those undertaking a course on moral and political choice, were interviewed on one

occasion whilst students and again several years later. One participant, Claire, commented in the second interview that what she would personally describe as moral growth would, she suspected, be viewed by Kohlberg as being no progression at all. She felt that earlier in her life she had a greater capacity for moral certainty that she had by the age of 27:

> It seems to me that at one stage of my life, I would have been able to answer these dilemmas with a lot more surety and said, 'Yes, this is absolutely right and this is absolutely wrong'. And I am just sinking deeper and deeper into the mire of uncertainty. I am not sure if that is good or bad at this point, but I think there has been, in that sense, a direction.
> (Gilligan 1993:p55)

Gilligan links this type of response with the studies carried out by Perry (1981), which identify changes in thinking that mark transition from a belief that knowledge is absolute, to an understanding of the contextual relativity of both truth and choice. As I highlighted earlier, in my discussion of Perry's work, this increased doubt, over time, about the unshakeability of moral absolutes, concomitant with an increased awareness of contextual complexity, is a feature of the accounts of the students within my own study.

Gilligan points out that, for so long as the categories by which development is determined are derived from research on men, divergence from this masculine standpoint will be viewed as problematic. Additionally, if women experience the constant reinforcement that their moral 'voice' is deemed inferior to that of the norm, they will be discouraged from its explication.

Gilligan, referring to her study of college students of both sexes, suggests that, although there are substantive differences between men and women, both move from adherence to moral absolutes over a period of time (in this instance, the 5 years subsequent to their initial interview) and develop an awareness of multiple truths which renders judgements contextually relative. She cites Alex, a male lawyer[19], who described his previously-held views on justice and injustice as being complicated by a new understanding of human attachment (1993:p166).

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[19]I have deliberately used an example here of one of the men in Gilligan's study, as there is sometimes an explicit, or implicit, assumption made by writers that Gilligan's studies were exclusively of women.

Claire had worked as a counsellor in an abortion clinic and found it difficult to articulate the moral dilemmas that this caused her. Gilligan suggested that this:

> ...stems in part from the fact that hers is a contextual judgement, bound to the particulars of time and place, contingent always on 'that mother' and that 'unborn child' and thus resisting a categorical formulation. To her, the possibilities of imagination outstrip the capacity for generalisation. (Gilligan 1993:p58-9)

Once again, the foregoing links with the findings from my own study, in which Jane describes (Interview 27) how, as she became a more senior student, she acquired increased access to what she termed 'the wider picture'. This included awareness of the importance of the particulars of time, place and context in decision-making.

Gilligan, as a result of her study of women who were facing a decision about whether or not to have a termination of pregnancy,[20] proposes that the sequence of women's moral judgement commences with concern with survival towards a focus on goodness and then to a reflective understanding of care as the most adequate guide to resolution of conflicts in human relationships. Concepts of responsibility and care emerge as central in the women's constructions of the moral domain. Gilligan however stresses that her study was small, time and context-bound and not generalisable. She identifies the need for additional longitudinal studies in order to refine and validate the suggested sequence.

Gilligan concludes by emphasising the need to delineate, in research on moral development in adults, women's own descriptions of their experience. She says that her studies suggest that men and women may speak different languages that they assume to be similar, if not identical, and that this may lead to mis-translation by listeners and consequent misunderstandings. However, it is only by positing two different modes of social and moral experience, as opposed to the single one assumed by previous male researchers, that a more complex rendition of experience may develop.

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[20]Twenty-nine women participated, from whom Gilligan obtained a complete interview with twenty-four. Twenty-one were interviewed on a second occasion, one year later.

Gilligan's work provoked a voluminous response, both supportive and critical, from a variety of disciplines; psychology, sociology, feminist theory and nursing. One reason provided for the attention that it received, and the subsequent development by others which it has generated, is suggested by Kroeger-Mappes (1994). She points out that, whilst the work is of specialist interest, for example to those in the academic disciplines cited earlier, it also has an appeal to a wider and more general audience. Davis (1992) describes Gilligan's work as being successful, although not from an academic point of view (Davis is critical of what she perceives to be Gilligan's lack of academic rigour), but because it attracts attention as a result of its challenge to the status quo and in its development of an alternative point of view.

The work of Hekman

Hekman (1995) provides an extensive examination and critique of Gilligan's work and, in doing so, argues that Gilligan's approach entails recognition of a multiplicity of moral voices, of which gender is but one.

Hekman (1995) says that:

> It does not overstate the case to say that Gilligan's work has revolutionised discussion in moral theory, feminism, theories of the subject, and many related fields. *In a Different Voice* is unquestionably one of the most influential books of the 1980s. It has been both criticised and praised by feminists, moral philosophers, and moral psychologists.
> (Hekman 1995:p1)

With reference to the critics who describe Gilligan's studies as methodologically unsound and theoretically confused, Hekman counters that the point of general agreement is that the moral, epistemological and methodological ramifications of the work are still being explored and that this is an area which Hekman herself wishes to pursue. She says that:

> It is my contention that Gilligan's work is both an indication of, and a major contributor to, a sea change that is under way in late twentieth-century intellectual thought. In almost every branch of intellectual life, the twentieth-century has witnessed a move away from the universalism and

absolutism of modernist epistemology towards conceptions that emphasise particularity and concreteness...many twentieth-century thinkers posit a subject who is embedded and situated, constituted by language, culture, discourse, and history.
(Hekman 1995:p2)

However, Hekman states, one discipline which has resisted the above has been moral philosophy, which retains as its foundation the concepts of rationality and autonomy, with the sine qua non of moral discourse being the ability of the subject to abstract from the particular and to formulate universal moral principles. This being the case, Hekman argues that it is naive to expect that millenia of hegemony may be rocked, let alone overcome, by a proclamation. Hekman suggests that, although Gilligan does not cite Kuhn, his proposal that theories constitute their own set of facts may be used to explain why Kohlberg and his adherents are unable to hear the moral voice of an ethic of care[21]. Gilligan conveys this idea when she argues that:

There is no data independent of theory, no observations not made from a perspective. Data alone do not tell us anything: they do not speak, but are interpreted by people.
(Gilligan, in Kerber et al 1986:p328)

Hekman makes the additional point that, in her view, all moral theories are inextricably linked to specific epistemologies and says that:

Like Kohlberg's, Gilligan's own theory creates its own facts; she can hear the different voice as moral only because her conception of morality encompasses the realm of the particular and the personal.
(Hekman 1995:p29)

Hekman suggests that it follows from this that, although Gilligan claims that the moral voice that she identifies is complementary to that of Kohlberg, her conception of the moral domain and the moral subject are incompatible with modernist moral theory and integration is thus impossible. Gilligan's theory

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[21]Hekman does not provide a specific citation here, but the reference may possibly be Kuhn (1970). Kuhn's argument is that knowledge is conservative, insofar as new knowledge is perceived *within* the current hegemonic framework. Unless this underlying structure is challenged there will be a tendency to reinforce, rather than replace, existing conceptions.

negates the modernist model in its proposal that relationships equate with health, the corollary of which is that detachment and autonomy may be deemed 'unhealthy' and, as such, to be avoided where possible, as opposed to being accorded value.

Hekman argues that Gilligan's research on the different moral voice goes beyond a reformation of the dominant tradition of Western moral thought and, instead, provides a radical transformation of it. In Hekman's view, one reading of Gilligan's work suggests that she argues for the replacement of one 'truth' by another, but that a second reading suggests, rather, the proposal for a reconstitution of the moral realm, transcendent of dichotomy. It is this latter conceptualisation that Hekman pursues in her book. From my own reading, and interpretation, of Gilligan it seems that, although she overtly identifies the latter as her aim, she at times, clearly conveys the idea that an ethic of care is 'better' than that of justice.

It is Hekman's central argument that Gilligan's researches signal the existence of a multiplicity of moral voices, ie those embracing race, class and culture, rather than the justice and care voices upon which she focuses (linked as these are, in Gilligan's view, with a masculinist and feminist mindset). She states, however, that Gilligan's later work indicates an awareness of this multiplicity (although I do not find this accorded emphasis within the 1993 preface to *In a Different Voice*). Hekman contends that "...gender, race, class, hegemony, and subjectivity are not optional aspects of moral theory but, rather, necessary elements of any account of morality" (p48). Whilst acknowledgement of the muti-factorial nature of morality may complicate depiction of the moral domain, she asserts that this is both necessary and useful and it is her contention that moral voice is an integral and inseparable part of the whole person, as opposed to being an objective, superimposed entity extraneous to other, subjective, structures[22]. Hekman (1995:p110) cites Minow, who states that:

> Denying the multiplicity of moral perspectives and demands does not make them go away; instead it marks a rigid either/or thinking that constrains moral understanding.
> Minow (1990:p222)

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[22]cf Kohlberg and Rest

These assertions reject the Cartesian view of the individual as one possessing an autonomous ego which may conceptualise essential qualities or principles divorced from substantive circumstances, but links, rather, with Chodorow's (1978) 'object relations' theory, which posits that one's idea of the self is a wholly relational product, ie one does not possess an essential core, but becomes a 'self' by means of relationships with others. From this perspective, Hekman states that any concept of possessing a 'separate' autonomous self is itself a product of relational forces. In relation to her own stance, Hekman counters the claim made by defenders of modernist theory that abandonment of universal moral principles entails moral relativism and "the babble of countless moral voices" (p31). This criticism is only relevant if the issue of morality continues to be cast in dichotomous terms ie opposition between the absolute and the relative. She cites Frye (1991:p52-59), who asserts that the desire 'to get it right' and identify one all-embracing theory is the mind-set of a particular class, race, culture and situation and that what is required is a plethora of ethics.

Hekman states that her own stance is not that of relativism but, rather, a move that displaces such a dichotomy and defines knowledge as situated, connected and discursively constituted (p32, p97). In relation to relativism, Hekman (1995:p155) cites Rorty's (1989:p50) argument that relativism is no more a problem for those who disbelieve in absolutes than is atheism for those who lack belief in a deity.

She argues that, whilst many other contemporary theorists, for example Nussbaum (1986), Blum (1986, 1988) and Baier (1985), suggest that their work moves the debate on from traditional moral theory, they nonetheless attempt to identify one all-encompassing theory explanatory of moral reasoning and behaviour. Hekman argues that all who define their approaches as being situated along an absolutist/relativist continuum fail to offer a viable alternative to modernist moral theory. There is additionally, in her view, a failure of many theorists to differentiate between the wide variations amongst different men and different women and, instead, a desire to homogenise experience.

Hekman concludes that her overall purpose has been to take Gilligan's (1982) argument and extend it to include a multiplicity of voices, for example those which are constituted by race, class and culture.

The care ethic of Noddings

Another writer, less influential than Gilligan, but whose work has nonetheless attracted considerable discussion and debate and is cited by many who propose that an ethics of care is appropriate for nursing, is Nel Noddings (1984, 1989, 1990). It is the use of Noddings' work by some nursing theorists that is my rationale for providing the following description and evaluation of her work, as I shall argue that her (1984) work, which is the one most frequently cited, is inappropriate for those involved in the provision of what Davies (1995) describes as 'professional care', ie that for which practitioners receive a formalised preparation for practice and in which care provision and receipt is between those whose relationship is founded upon a public, rather than domestic, 'contract'.

Noddings advocates an ethics based upon what she terms 'natural' caring, which is rooted in receptivity, relatedness and responsiveness, and makes clear that she considers this to be superior to ethical or moral theories which are principle-dependent. Noddings denies the validity of the latter approach (1984:p43, p55 <u>et passim</u>), based on her view that the concept of universal principles constitutes what she terms 'romantic rationalism' (1984:p3, p159). She asserts that moral action is context-dependent and that it is impossible to abstract moral reasoning or judgement from the concrete situations in which they are grounded.

There are, however, a number of inconsistences in her approach. For example, when she says that, "...it seems preferable to place an ethical ideal [ie her own conception of an ethic of care] above principle as a guide to moral action" (1984:p84), she is arguably proposing a universal principle herself (ie proposing a guide for application in each and every situation). This is a criticism made by a number of writers, for example Kuhse (1997).

Noddings states that her reason for not resorting to principles is that ethical caring is dependent, not upon these, but upon the development of what she terms an 'ideal self'. This is predicated upon "...one's best remembrance of caring and being cared-for." (1984:p94) The implications of this statement for those who have received little care, or that which has been unsatisfactory, are not addressed.

Noddings asserts that, whilst she ascribes her view as 'feminine', this "...does not imply that all women will accept it or that men will reject it...[rather] it is feminine in the deep classical sense - rooted in receptivity, relatedness, and responsiveness." (1984:p2). Despite having made this statement to the effect that her comments are not gender-specific (whilst concomitantly proposing what appears to be an essentialist view of gender), her use throughout the book of the female pronoun to denote the one 'caring-for' and the male pronoun to denote the 'cared-for', in addition to her use of the experiences of women in relation to an ethic of care and men in association with universal principles, outweighs her initial assertion.

Noddings' writing supports Hekman's argument (Hekman 1995:p9) that a denial of the existence of universal principles illuminates the unavoidable impasse between modernist moral theory and those who suggest a supplantation, or reformation, of the basic tenets upon which it is predicated. Noddings' assertions lie outwith the language of traditional moral discourse, the continuing hegemony of which denies legitimacy to other perspectives.

It is possible, however, as some writers have done (for example Tronto 1987), to criticise Noddings on her own ground, without disparaging her departure from traditional moral discourse. Noddings' assumptions, firstly, that care is a 'natural' emotion and, secondly, that the 'natural' equates with the 'good', are clearly open to debate. It is not only questionable that the emotion of caring for others is inherent, as opposed to being generated by life experience, but also that unqualified association of the natural with the good is tenuous. Noddings, however, explicitly equates the former as being synonymous with the latter (1984:p70, p79-80 et passim).

A serious criticism of Noddings' perception of caring, in relation to its relevance to nursing, is that it is parochial in the extreme: whilst she is critical of Singer's (1979) view that one's ethical obligations to other living creatures are virtually limitless (1984:p151-152), she replaces this with an emphasis upon reciprocity which is problematic (1984:p69-74, p149-156 et passim). She identifies that reciprocity and relationship between the 'caring-for' and the 'cared-for' is a prerequisite for care-giving, but fails to address the problem posed by those who are unable to reciprocate (for example those who are brain-damaged). Following the logic of what Noddings says in relation to reciprocity her obligations to care for her cat (1984:p155-157) exceed those which she has in relation to most other

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living creatures. Having said that moral obligations to care extend only to those within one's immediate circle of contacts (and who are able to reciprocate, ie provide some positive feedback) she does not identify what happens to those outwith this charmed circle. That an institutionalised framework of care provision for such people, or for those whose carers are unable to cope unaided, might be required is completely unacknowledged within her book. Following Noddings' line of thought, even were such institutions established, there remains the problem that, in the absence of reciprocity, potential care-providers would be unable to summon the ability to care and many individuals would thus remain uncared-for. The wider implications for society in other respects are similarly unaddressed, the reader being left with an impression that family units, or tribal communities, living in isolated self-sufficiency may survive, but that any concept of societal obligations beyond this are virtually absent, even by implication, from her account.

Kuhse (1997) provides a similar criticism to the above, arguing that Noddings' ethic of care is inappropriate for extrapolation to, and application within, the nurse/patient relationship. Her additional criticism, however, diverges from my own, when she asserts that Noddings' approach should be rejected by nurses because of its divergence from the traditionally accepted language of moral discourse. Nurses who depart from the latter will, Kuhse (1997:p144) states, exclude themselves from the ballpark of moral debate (and rightly so, in her view).

In conclusion, my own view of Noddings' work is that, whilst is of interest in its challenge to the epistemological status quo, it does not appear to offer an ethic which is relevant or appropriate to 'professional' providers of health care.

Partialist versus Impartialist approaches

Rickard et al (1996)[23] argue that the connection frequently made between nursing and caring originates in established occupational and gender stereotypes and also in an explicit appropriation, by some nurses, of an ethic of care with which to support their quest for a professional identity discrete from that of other health care practitioners. This latter point has led nurses to affirm their experience and self-conceptions in the works of Gilligan and Noddings.

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[23]The co-authors are Kuhse and Singer.

Rickard et al (1996) propose that, rather than talking in terms of an ethic of justice and ethic of care, it is more helpful to distinguish between 'partial' and 'impartial' moral reasoning. They argue that:

> The former, which is a central feature of the care orientation, involves judgments that emphasize personal attachments and favour those with whom one is personally connected in situations in which their interests compete with those of others with whom one is not personally connected. Impartial reasoning, on the other hand, is typical of standard ethical conceptions, and involves judgements that are detached and do not favour personal attachments, but reflect a concern for what equal consideration and wider impersonal duties require. The equal consideration and impersonal concern for duty and responsibility that is typical of impartial reasoning is expressed in terms of universal rights, rules and principles.
> (Rickard et al 1996:p215)

Rickard et al (1996) carried out a study, with the aim of exploring the extent to which nurses display partialist, and doctors impartialist, reasoning by means of a structured questionnaire, based upon four hypothetical dilemmas. The authors' stated rationale for this method of data collection is that it allows for greater control of content than is achievable if participants self-select issues for discussion and renders data more amenable to quantitative analysis. They state that, "The variable content and subjective importance of self-selected dilemmas were seen to present an unwanted possible influence on reasoning orientation" (p216). This approach does however ensure that it is the researchers' conception of what constitutes a moral dilemma that is taken as the 'correct' definition and it involves the sacrifice of complexity in favour of a readily-boxable response.

Rickard et al's (1996) findings were that there was no significant divergence between the reasoning of nurses and doctors, but that, in situations in which lives were at stake, all groups favoured a partialist approach. When the situation was not life-threatening, but occurred within a professional context, the majority favoured an impartialist approach, but when it occurred outwith this, participants were almost equally split between an impartialist and partialist approach to the dilemma (p217). The results, then, demonstrate that nurses and doctors reason in both modes, dependent upon different occasions. The authors query whether this

indicates that, from a philosophical perspective:

> ...there is some basic inconsistency, disunity or confusion in the ethical thinking of health care professionals...[or whether] there is some broader philosophical understanding of ethical reasoning that can reconcile partialism and impartialism as different aspects of the one conception of moral thinking? (Rickard et al 1996:p217)

They attempt to overcome this problem, not by consideration that 'philosophical understanding' may per se be fallible, but by using Hare's (1981) two-level distinction between 'critical' and 'intuitive' responses as a possible accounting for the waywardness of the participants' responses. Critical responses conform to an idealised appreciation of, and measured response to, a situation but, as the contingencies of life may on occasion preclude this approach, an intuitive response may be made. The authors identify the critical approach as that which will invariably produce the correct response in any given situation, but do not acknowledge evidence from its institutionalised embodiments, for example the judicial system, that do not support this sanguine expectation. It may be argued that, embedded within the 'impartiality' of the critical approach (supposedly its strength), lies its weakness, in its failure to engage with issues from the perspective of the substantive participants.

Kuhse (1997), a utilitarian, asserts throughout her work that, "... acceptance of something as a *moral* principle is dependent on universalisability" (p80-81). Kuhse states that "...the central question is not *whether* context is relevant, but rather *which* elements of a particular context ought to be 'abstracted' from the overall context as significant for ethical decision-making" (p121). (Emphasis in original.)

Kuhse's utilitarian beliefs lead her to be critical of multi-principle approaches per se, as being cumbersome and difficult to rank in terms of priorities (1997:p130), but she argues that utilitarianism does account for the individual within the overall requirement to create the greatest benefit for the greatest number. It is, of course, possible to argue that the clarity afforded by a utilitarian approach is illusory and that 'messier' approaches are a prerequisite for an adequate understanding of, and response to, life's complexities.

Kuhse identifies the problems engendered by the different meanings accorded to 'care', arguing that some are an inaccurate description of what nursing is, or should be (p146-150).

Tappan's concept of moral functioning

Tappan's (1987, 1989) concept of moral functioning is of interest in relation to the findings from my own study, as his research was longitudinal and examined the moral development of college students over time. His doctoral study (Tappan 1987) reports in detail on four college students: two men and two women, from an original study comprising five men and five women who were undertaking an introductory course in moral philosophy at Harvard. Tappan collected data by means of semi-structured interviews which were carried out at monthly intervals, using scenarios and life-experiences in order to stimulate discussion.

The aim of the study was to explore short-term changes in what Tappan orginally described as the 'moral reasoning' and, in the light of data, altered to 'moral functioning', of the participants during their freshman (sic) year. Tappan considers that the latter term more clearly acknowledges the complexity of the cognitive, affective and conative aspects of the processes involved, whereas Kohlberg's approach prioritises the first to the exclusion of the others. Tappan argues that to suggest that a response to a dilemma is purely cognitive is a failure to acknowledge the intricacy of the processes which take place. It may, of course, be the case that responses to abstract dilemmas are more amenable to a purely cognitive response than are substantive dilemmas in which the participant has been personally involved. Tappan states that his aim was to combine and integrate different approaches to the study of moral development. He utilises the theories of Kohlberg (principles of justice), Gilligan (care, responsiveness) and Perry (ability to commit to, and uphold, a moral position whilst acknowledging relativism).

Tappan identifies, as did Perry (1981), that little research has been undertaken into the processes, as opposed to products (such as developmental stage acquisition), of moral functioning (Tappan 1987:p4). He argues that the focus, within developmental psychology, had imposed meaning upon participants, rather than reconstructing it from the participants' perspectives. (Whilst I should consider a

claim to have identified processes within my own study as overly-ambitious, it was possible to identify changes and to explore the rationale for these with the students.)

Tappan does not claim that his own study was 'objective' and acknowledgement of his own standpoint is made when he states that:

> ...I have based my analysis of developmental progress on my belief that moral functioning that is based on a commitment to a particular moral vision in full awareness of the relativistic nature of the moral world is more adequate (ie more highly developed) than moral functioning that either has no awareness of relativism, or is consumed by it.
> (Tappan 1987:p222)

Tappan identifies the dialectic between the participants' accounts of their own development and the theory which the researcher then utilises in order to interpret the data (Tappan 1989:p302). Tappan cites Hirsch's (1967) differentiation between the *meaning* of a text, determined by the author, and its *significance*, determined by the reader. Tappan states that he advocates the stance of viewing those in late adolescence as being legitimate interpreters of their own developmental progress (Tappan 1987:p230). His conclusion is that short-term developmental change in moral functioning during late adolescence is best understood as a function of a developmental narrative that is, first, experienced, then recounted. Tappan does not, however, identify the multiplicity of recounting. This occurs, in the first instance, as a discourse with oneself, in order to make sense of the experience, and to modify, integrate, accommodate or reject it. Subsequent to this there may be a recounting of the experience to others and this may entail the use of differing discourses with different people in a variety of contexts. He does not appear to address in detail the iterative nature of the recounting, for example, the manner in which one's account is received by others may modify the subsequent recounting to oneself and so on. This was an issue of which I was acutely aware within my own study, the implications of using narratives as research data being discussed within Chapters Three and Four.

Upon completion of the study, Tappan identified that the participants' moral justice reasoning had not undergone changes in a way which Kohlberg's model would acknowledge, but that a reading of the individuals' consecutive transcripts indicates clearly that changes had taken place. There was a shift from utilisation

of universal principles towards a realisation that the complexities of situations in life render adherence to abstract principles problematic. This links with data from my own study, the students' perception being that a reliance upon principles is easier when a restricted view is taken, than it is in the light of the contextual nuances of substantive situations.

Tappan does not make any claim to have objectively tested or verified Perry's theory, nor rejected Kohlberg's, although he does argue that:

> ...the correspondence (or lack thereof) between personal narrative accounts of developmental change over time and theoretical narrative accounts of developmental change over time is significant.
> (Tappan 1989:310)

He suggests that the relationship between personal and theoretical narratives reveals less about the 'truth' of tangible events than it does about the common cultural forms of discourse which relate to events occurring over time (1989:p3ll). He also argues that the lack of correspondence between Kohlberg's and Perry's theories is meaningless, in that they are designed to examine very different dimensions of moral experience. The former's concern is to describe and explain relatively tacit 'deep' structures, whilst the latter focuses upon the more explicit processes of self-reflection and self-reporting.

In relation to evaluation of his findings he says that:

> ...the best that can be done is to judge not truth, but versimilitude - and that only with hermeneutic uncertainty.
> (Tappan 1989:p311)

Manning's *different voice*: compromise and accommodation

A writer who concurs with Hekman's view (ie, that previously identified sex differences in moral reasoning have been over-emphasised and that influences on the making of moral judgements are multi-factorial) is Manning (1992). She suggests, from the findings of her own research, that differences between females and males may be resultant more from differences in their gendered background, rather than to differences in reasoning style.

Manning's interest was stimulated by her contact, as a lecturer, with students. This convinced her of the aridity of standard ethical theory and the necessity to identify and explore the voices of individual moral agents. In her own study, Manning used an adaptation of an Aesop fable in order to gauge the influence of gender, class, age and race upon moral reasoning, selecting a dilemma which she considered would be open to any moral voice. That the subject material of the hypothetical dilemma related to animals other than humans may render extrapolation of the study's findings to a human interaction context problematic. However, Manning's focus of interest lay in the rationale provided by participants for their actions, although it can, of course, be argued that any given rationale is, or may be, context-dependent. The participants in her study were 160 undergraduate students on commencement of a course in professional and business ethics: of these 118 agreed to take part. The students were ethnically mixed and comprised 56 men and 62 women.

The story of the moles and the porcupine was narrated to the class: initially, emphasis was placed upon the laziness of the porcupine in not having dug its own burrow and imposing upon the moles in theirs. She asked participants to write their initial response, then to provide an answer written from an alternative perspective and then to write a reflective account about which response was preferable to them. Further narrative information was then supplied, in order to identify whether specific factors elicited a different response. One supplement stated that the the porcupine's own burrow had been destroyed, rendering it homeless, another that the porcupine would die if denied admission by the moles and, finally, that the moles might suffer serious damage if they permitted the porcupine's admission.

Manning's (1992) findings indicate that those working within 'service' industries provide the most accommodating response, those who are 'professionals' the least (p39).

In relation to age, the students aged 18-22 years were more accommodating of the porcupine that those between 23-27 years. However, amongst individuals aged 27 or older, it was the case that 60% of men and 100% of women agreed to accommodate the porcupine (p41). Those who had children were more than twice as likely to be accommodating as those who were childfree. (Identification of

participant responses with different socio-economic status would have been of interest, but was not provided.)

In relation to ethnic origin, 80% of Latino-Americans identified the need to accommodate, compared with 28% of Anglo-Americans and 11% of Asian-Americans. (This finding, as with the others, is open to a variety of interpretations. The seemingly low level of accommodation identified in those of Asian ethnic origin might, for example, derive from experience of racial prejudice and discrimination and a need to bond with those of their own cultural background in order to protect themselves against threat.)

The participants provided a variety of reasons for their responses, quite a number saying that they should accommodate the porcupine per se. Manning said that, initially, she viewed this as a non-response, but later realised that it appeared to be a voice which argued for the value of compromise and accommodation as an end in itself: she associated this with an ethic of care (p48-49). Another finding which was of interest was that participants changed their justification for action in response to an alteration in context, ie they did not apply principles which were universal (p52). The importance of context in moral decision-making links with the findings from my own study, some students reporting application of universal principles easier to accomplish in the abstract than in relation to individual patients, of whom they possessed specific knowledge.

In Manning's (1992) study, as the prospect of harm to the moles increased, and thus the possibility of accommodation of the porcupine decreased, there was a move by participants to provide justification for their action in terms of abstract principles (p56). Manning does not speculate about the possible explanations for this finding, but it may be the case that, when circumstances necessitate action which an individual considers unpleasant, they cite 'inexorable' principles as their rationale, in order to dissociate themselves from the behaviour and its consequences. Alternatively, if the number of individuals whose interests require to be considered is large, the prospect of accommodation of varying interests may be daunting, if not overwhelming, and the option selected by decision-makers may be the application of unwavering principles.

Manning (1992) identifies a lack of research studies into the moral reasoning of adults and suggests that life experience may be a significant factor in explanation

of different responses (p40). She argues that any ethic develops out of lived experience, attachments and sense of personal integration, ie, it is grounded in relationship and response (p.xiii), and she is critical of the 'textbook' model of moral reasoning which assumes that all moral 'problems' have a 'solution' and that its location is within generalisable principles (p20). Manning is in agreement with Hekman when she asserts that our moral conceptions rest upon ultimately 'unjustifiable' value commitments, but that these are not arbitrary and are indeed integral to, and inextricable from, our identity (p27).

Manning acknowledges that the small sample in her study precludes claims of generalisability and identifies the need for more work in relation to the effects of age, socio-economic class and ethnicity upon moral reasoning. Her conclusion, however, from her own findings, is that there *is* a different moral voice, of compromise and accommodation, which has hitherto not been identified or acknowledged in research findings, but that she is unsure that it is a *female* voice (p56).

One comment which is applicable to much of the work of Kohlberg, White, Perry, Tappan and Manning is that the participants in their studies are frequently students undertaking courses in the same educational institutions as the researchers and thus co-inhabitors of a mutually-recognisable world. The courses which the students are undertaking often relate to moral reasoning, or to ethics. The researchers seldom, however, acknowledge the potential, or actual, impact that these foregoing factors may have upon research findings, for example in rendering them self-referential. If claims of generalisability beyond the rarified world of higher education are not made, then perhaps this is unproblematic, but Perry (1981), for example, suggests that the course of cognitive and ethical development which he outlines appears to be a constant phenomenon within a pluralistic culture, despite the fact that the participants in his studies were Harvard students.

Having outlined the work of some theorists and researchers whose studies have been undertaken in a variety of settings, qualitative research which explores the moral reasoning of *nurses* will now be identified and discussed.

Qualitative studies into the moral reasoning of nurses

Parker's Relational Ethic

Parker (1990) has been criticised by some for his adoption of a relational ethic of care for nursing, on the grounds that it is inappropriate, or unrealistic, or both. Whilst the close, inter-dependent, one-to-one relationship between patient and nurse which he describes would indeed be difficult to sustain within the constraints of the health care system, even by those who consider it desirable, Parker does, nonetheless, acknowledge the need to identify boundaries or limits within a relational ethic. An issue which he raises is that of the devaluation of nurses' own descriptions of moral conflict in practice. He highlights the proliferation of nursing ethics literature, almost all of which presents the reader with a pre-set nursing dilemma which is then processed by means of an ethical decision-making model in order to arrive at potential solutions. He is critical of the use of tools such as Rest's (1976) DIT, in which hypothetical situations unrelated to nursing are used to assess nurses' moral reasoning against an existing moral theory. Not only do replies to hypothetical dilemmas fail to identify unequivocally the actions which individuals would take in reality but, as Parker says, "Rarely, if ever, do authors use nurses' moral experiences to evaluate the adequacy of moral theories" (1990:p35).

Parker (1990) asserts that,

> ...exclusive reliance on abstract moral principles can narrow the range of alternative solutions and prompt a premature and final decision in a moral conflict...[although the] claim of moral rationality is seductive because it gives the mistaken impression that moral certitude is attainable.
> (Parker 1990:p36)

Parker (1990) argues that uncertainty, rather than indicating a failure of rationality, provides a reminder of its limits and that, "...moral ambiguity and distress are inalienable dimensions that define the very nature of moral judgments and moral agency" (p36). Parker also identifies the problems that organisational constraints pose for nurses, the majority of whom practice within care delivery systems with a rhetoric which advocates teamwork, but a framework which functions as a traditional hierarchy of contractual relationships.

Pierce: *The Moral Dynamic*

Pierce (1990, 1997) identifies the lack of empirical study into the holistic and inter-related nature of what she terms 'the moral dynamic' in people's lives and her (1990) doctoral work describes her own research, the aim of which was exploration of the moral reasoning of physicians and nurses. She emphasises that the limited numbers (n=21: 11 physicians and 10 nurses) and qualitative nature of the study preclude claims to generalisability, but the findings are of considerable interest in the light of the different approaches to care identified by the students in my own study as belonging to members of different occupational groups.

Pierce's study involved an open-ended interview with participants, in which the agenda comprised identification and exploration of self-views, world-views and values. Participants were asked to process, and provide verbal comment upon, three written, fairly detailed, illustrations of conflict situations within oncology settings. Participants were also encouraged to raise any other ethical issues which they considered relevant and several included in their discussion of the scenarios direct references to their own experiences within similar situations.

Pierce subsequently coded interviews according to pre-selected components or themes identified within the moral reasoning literature (Kohlberg 1976, Gilligan 1982). The results from this process indicate that three processing perspectives emerge as the defining feature of the moral dynamic of the participants.

The approach which she describes as 'science dominant', is driven by the type of theory-led cognitive processing and reliance upon abstract principles and rules described by Kohlberg (1976). Another approach, the 'person dominant', is one in which health care professionals provide information which enables patients to identify for themselves the course of action which they deem to be the most appropriate. In order to achieve this, the practitioner requires knowledge of the specific issues relevant to each particular patient and cannot therefore rely upon universal principles in order to determine what should be done. Pierce links the person-dominant perspective with the approach to moral reasoning proposed by Gilligan (1982).

The third approach, which she calls the 'science/person equilibrium', involves the outcome, purpose, goals and obligations being weighed and balanced in relation to both 'science' and 'person'; in other words a synthesis of the science-dominant and person-dominant perspectives. The outcome of this approach appears to be a combination of 'scientific' benefit with benefit as defined by the patient, neither being considered in isolation of the other. The nature of knowledge in this approach is defined as a combination of the objective and subjective, rather than the two being viewed as dichotomous. Pierce suggests the science/person equilibrium as the approach most likely to benefit patients, as it acknowledges, and makes provision for, the complexity of the situations in which moral decision-making is required in reality. It was, however, a perspective demonstrated by few (n=4) of the participants, all of whom were physicians. Eighteen of the participants were consistent in their perspective, the remaining three having a more eclectic and less readily identifiable approach. Pierce does not provide details of the approaches of these three participants, making evaluation of their responses problematic. If, for example, categories such as 'science-dominant', 'person-dominant' and 'science/person equilibrium' are pre-selected by the researcher, then responses which cannot be relegated to one of these may be deemed to be maverick, rather than perhaps indicative of more complex underpinning processes. Five of the physicians and none of the nurses demonstrated a science-dominant perspective, whilst nine nurses and no physicians demonstrated a person-dominant perspective. Those who demonstrated a preference for either the science-dominant or person-dominant perspective tended to reduce the amount of information which they took into account in any given situation and achieved this by according secondary status to the information relating to the perspective other than their own. Whether this is attributable to the individual's personality, or to the differing occupational focus and requirements of medicine and nursing, is not identifiable, although the findings of Lindseth et al (1994), disussed in Section One, are of interest in this connection.

Pierce concludes that the nurses and physicians in her study demonstrate a moral dynamic which operates from different vantage points, but that professional roles appear to be the determinant of perspective, as opposed to gender, as there is no clear female/male difference in approach. It is difficult to link some of Pierce's overall findings with those from my own study, as I did not attempt to provide dichotomous categories for the students' responses. Were I to attempt such an exercise, it would probably be the case that the students would be more readily

relegated to a 'person-dominant' approach, but this is too rigid a categorisation to do justice to the complexity of some of their comments. It might also be misleading, in that, whilst the students did not often discuss the relevance of 'science' to patient care, the nature of the students' comments indicated that this was not due to denigration of its importance in the scheme of things but, rather, that it was deemed too obvious to be worthy of specific attention.

The means by which Pierce organised data is open to the criticism that she commenced with two previously identified approaches, ie those of Kohlberg and Gilligan, and subsequently employed these as dichotomous yardsticks by means of which to categorise emergent data. She did not, however, allow the pre-existing literature to blind her to the previously unidentified synthesis of the two approaches utilised by some participants. The use of vignettes as a focus for discussion is an approach upon which I have made critical comment earlier, but Pierce's vignettes, included in an appendix (Pierce 1990) are not simplistic, did not involve theoretical abstractions (cf. Kohlberg's hypothetical account of Heinz and the drug) but, rather, were grounded in situations similar to those encountered daily by the study's participants and were used by her to stimulate discussion, as opposed to providing participants with a straightjacket.

Perspectives on care: medical and nursing staff

That apparent differences in moral perspective are not necessarily sex-linked is supported, albeit in a rather different way, by the study (n=32: 23 nurses and 9 doctors) carried out by Uden et al (1992), who found a divergence in ethical reasoning between nurses and doctors, which appeared to be occupation-linked, as opposed to gender-related.[24] The nurse participants tended to discuss experiences within the framework of a care orientation, whereas the medical staff utilised what could be identified as a justice perspective. Uden et al interpret these differing perspectives as attributable to the nature of nursing and medical work.

Uden et al's (1992) findings were, however, subject to some revision in the light of a follow-up study (Lindseth et al 1994), in which the original research participants

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[24]The 23 nurses comprised 20 women and 3 men
   The 9 doctors comprised 4 women and 5 men

who were still working within the same hospital were interviewed.[25] Participants
were provided with a summarisation of data from their first interview and asked to
elaborate upon it. It was noted that, when asked about dilemmas which were
job-related, the nursing focus was upon process, whereas that of medical staff was
upon outcomes. However, when asked to reflect upon the first interview, all
participants provided a personalised discussion with reference to their own
experiences of caring and being cared for and, in this, the similarities between all
participants were greater than the differences, with the overall focus being upon
closeness and caring.

It was tentatively suggested by the researchers that the nature and demands of a
particular occupation are perhaps, then, what encourages or necessitates a
particular approach, rather than this being indicative of the qualities of an
individual per se.[26] No claims are made for generalisability of the findings, due to
the small numbers involved and the qualitative nature of the studies. Some of the
staff were from an oncology unit and some from a medical unit and there appears
to be a greater focus on care aspects in the former group, raising the possibility
that this, too, relates to the differing occupational demands involved.

Holm et al (1996) aimed to study the ethical reasoning of nurses and physicians,
using focus groups as a means of data collection. Participants were provided with
three case studies, which they discussed, in order to decide upon the action which
should be taken. Focus group data were subsequently categorised according to
ethical content (deontological or teleological), type of statement (for example
clarifying, responding, discussing) and linguistic style (assertive/non-assertive).

It is of interest that quite a large proportion of the statements made by the
participants in Holm et al's (1996) study were, at least in part, aimed at elaboration
and clarification of context. This has links with the students' narratives within my
own study, in which background information on the substantive situation under

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[25]n=13 registered nurses and 8 physicians.
[26]It might also suggest either that occupations attract people who possess a
distinct perspective which appears to be suited to practice within that occupation
or, alternatively, that people entering an occupation become socialised into
behaving in ways which seem congruent with its image.

discussion was often spontaneously provided, with the clear implication that this was of importance in understanding the decisions which had been made.

Holm et al (1996) point out that this need for contextual detail has implications for the reliability of research methods which use short scenarios and do not permit participants to request clarification. This comment also links with my own, and other lecturers', anecdotal experiences within our own university, of difficulties encountered in presenting students with short scenarios to act as a trigger for discussion of moral and ethical issues within small groups. In the feedback sessions from the groups of students, the frequent complaint is that the paucity of information renders decision-making problematic, if not impossible and the students' feedback is usually replete with qualificatory comments, which indicate the need for contextual detail as a prerequisite for any decision-making process. In a later work, Holm (1997:pll3) asserts that contextual awareness not only changes the solution to a problem, but also the way in which the situation as a whole is perceived.

No major differences were identified by Holm et al (1996) between nurses and physicians in relation to ethical content, neither occupational group utilising either deontological or utilitarian arguments to the exclusion of the other. In addition to the pre-determined theories:

> ...other categories of arguments which are not easily classifiable by this classic distinction, were used interchangeably, and were sometimes mixed within the same statement...The different choices made in these fairly similar groups indicate that the different moral considerations are played off against each other in complex ways, and there do not seem to be any simple priority rules which can resolve the participants' ethical worries.
> (Holm et al 1996:pl72)

In the light of the above, Holm (1997) added two further categories to the ethical content component, one of which related to development of good communication with patients and the other related to respecting patients as individuals. He identifies that any analysis carried out solely by reference to theories from moral philosophy is incomplete, due to the complexity of ethical reasoning, and that it is likely that some data will be contradictory. Within my own study the students' at times eclectic use of argument appears to be less indicative of a vacillatory inability to commit and more due to a recognition that the complexities of a situation necessitate a complex response. The relatively unstructured nature of the

interviews was advantageous in this respect, as it enabled me to ask clarifying questions on occasions when students apparently contradicted their earlier comments. This resulted in students being able to focus more clearly on the reasons for their different responses on each occasion. Examples of this will be provided within Chapter Four.

Whilst the pre-determined pigeon-holing of data into care or justice orientations to care is open to criticism, the findings of Pierce (1990, 1997), Uden et al (1992), Lindseth et al (1994), Holm et al (1996) and Holm (1997) are of interest and relevance to my study, as they appear to contain potential links with the differing approaches to care provision that the students identifed as belonging to different occupational groups.

Millette (1994) uses Gilligan's framework in order to analyse nurses' stories of moral choices[27], although the method of analysis sought evidence for justice as well as care reasoning. Twelve participants whose preferred choice in the orginal study (Millette 1993) had been client advocacy and twelve who had demonstrated a preference for bureaucratic advocacy were interviewed and were asked to describe a personally-experienced event that involved a moral choice. During this, the interviewer requested clarification as required. One of the major themes which emerged from the narratives was that of power and powerlessness, as facilitator or inhibitor of dilemma resolution.

The majority of nurses in Millette's (1994) study demonstrated an orientation to an ethic of care and there were, indeed, no participants whose description adhered to a purely justice-oriented approach, although in the seven narratives within which justice predominated, all narrators were still within active practice and five were in management positions. Of the participants in whose narratives a caring perspective was dominant, the majority were no longer practising nurses and none of those who argued purely from a care perspective were currently in practice. From these findings Millette (1994) raises the question of whether a justice orientation assists nurses to remain in practice and/or, conversely, whether a care orientation impedes this. Alternatively, one might query whether development of

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[27]The participants were selected from a larger study (Millette 1993), carried out in relation to advocacy. Although all participants were registered nurses, not all were currently in practice.

a justice orientation occurs as a defence against anxiety, an explanation which might link with Manning's (1992) finding that, as the prospect of accommodation of the porcupine becomes problematic, the reasoning of the study's participants' focuses more upon the use of abstract principles as the rationale for their actions. It may also be that, in the midst of a situation in which a rapid response is required, resorting to the application of abstract principles may expedite decision-making.

Norberg and Uden (1995) aimed to identify whether participants demonstrated differences in their moral reasoning according to gender, occupational group or health care setting. They found that the form of moral reasoning tended to be narrative in consideration of concrete issues and propositional when appeal was made to rules or principles. A total of 180 accounts of morally-problematic care episodes were obtained from enrolled nurses, registered nurses and physicians[28]. When participants were asked to provide a rationale for decisions made, this tended to reveal that they used principles (although the participants did not identify them as such). Enrolled nurses were found to demonstrate a care orientation, whereas the registered nurses and physicians, to an equal degree, demonstrated an orientation to both. No gender differences were noted. It was suggested that the closer involvement in direct patient care of enrolled nurses, as compared with registered nurses and physicians, might account for the difference, ie sustained, direct relationships may entail a focus upon a care perspective.

Grundstein-Amado (1993) interviewed nine nurses and nine doctors in Canada, in order to identify whether their ethical decision-making processes conformed to his theoretical model. His given definition of a model is, "...an intellectual device that simplifies and clarifies the sources of moral perplexity and enables one to arrive at a self-directed choice" (p1701) and, using extant models (citing Martin 1978, Siegler 1982, Candee and Puka 1983, Pellegrino 1987), Grunstein-Amado claimed to have, "...constructed a new comprehensive model that addresses their deficiencies" (p1702).

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[28]It should perhaps be noted that the study was undertaken in Sweden, a country in which patients' decision-making rights are codified in law. Institutionalised parentalism by physicians may be absent, or less evident, as a result.

Grundstein-Amado's (1991) model comprises three elements, the first being an ethical framework, which uses the principles of autonomy, beneficience and justice in conjunction with deontological and teleological theories. The second is a decision theory framework involving eight procedural steps, related to problem analysis and the identification and evaluation of available options. The third component is the contextual framework within which the decisions require to be made.

Participants in Grundstein-Amado's (1993) study were interviewed and asked to describe a critical incident in which they had been directly involved. The interviewer asked clarifying questions as required. Participants were then presented with a hypothetical ethical dilemma and asked questions in relation to this. The individual participants' responses to the different situations were then compared.

Grundstein-Amado (1993) acknowledges that the small sample size renders generalisation impossible, but suggests that the findings from the study indicate that, in relation to the ethical component and decision theory component, the participants did not follow a consistent and systematic pattern of ethical decision making. It is arguable here, of course, that the complexities of decision-making preclude a neatly-identifable categorisation and/or that the researcher's pre-set determinants were too rigid to accommodate complexity. Differences were evident between the participants' self-reported behaviour in the first phase of the interview and what Grundstein-Amado termed their "potential moral capability" in the second phase. Within the reality of clinical practice:

> [the participants']...decisions were made in a narrow, habitual manner, through the elimination of the most significant and demanding elements of the process...in the final analysis the individual decision makers tended to simplify their decision-making processes and to choose the solution that reflected their own ethical stances.
> (Grundstein-Amado 1993:p1708)

It is, of course, possible to question the implication in the above quotation that simplification equates with simplistic. It is possible, for example, that experienced practitioners might use their knowledge to arrive at a decision without explication of all the steps required en route.

Grundstein-Amado (1993) recommends further investigation into the subjective experiences of health care professionals and the need for formalised education programmes, in order to address the problems which he identifies.

Astrom et al (1993) provide further comment, which may link with the foregoing findings of Millette (1993, 1994) and Manning (1992). Their earlier study (Jansson and Norberg 1989) identifies the difficulties encountered by experienced cancer care nurses when asked to generalise, in the abstract, about patient care. The participants repeatedly emphasised the importance of context as being vital in determination of action in any situation. The researchers used narratives obtained from interviews with 18 experienced cancer nurses who had participated in Jansson and Norberg's (1989) study, in order to explore the previous findings in depth. Participants were asked to provide comments on the earlier research and to narrate care situations which they identified as problematic. These illuminate the importance of context in determination of the way in which situations are perceived by the nurse. This finding links with the centrality of providing care in context, which emerged as the core category from the students' accounts within my own study.

Some dilemmas in Jansson and Norberg's (1989) study were described by participants as being of an overwhelming nature, whereas others were possible to grasp. Some were characterised by feelings of solidarity with others, whilst in others the main feature was isolation. It was noted by Astrom et al (1993:p185) that, in the situations in which participants stated that they felt overwhelmed, they had a tendency to use the term 'one', as opposed to 'I', or 'we'. Astrom et al suggest that this may indicate the participant's feelings of alieniation or distance from such events. They also suggest a link with the participants' self-image, in that nurses who feel estranged may be more likely to select situations for narrative discussion which are of an overwhelming nature. The use of 'I', or 'one' may thus reflect either the situation or the narrator's self-image. Another possible explanation, which links with the findings of Manning (1992) and Millette (1994), is that of psychological distancing, as a defence, from situations which are threatening or, indeed, overwhelming in nature.

Inconsistencies between participants

Oberle (1995) undertook an exploratory study, the aim of which was to identify the possibility of designing a method, using written responses to hypothetical scenarios, by means of which to evaluate the quality of moral reasoning in student nurses. Qualified nurses in practice were interviewed in order to elicit ethical problems encountered in reality. Themes and sub-themes were identified by data analysis. Two scenarios were developed by the researchers, which incorporated the major themes. The second phase of the study involved distribution of the scenarios to students and qualified nurses (n=37) for written responses. Following this, a total of twelve experienced nursing professors and instructors from a sample of six institutions were asked to sort the responses according to perceived quality, from 'best' to 'worst'. Faculty members were then interviewed in order to identify the criteria used in the selection process.

The purpose of Oberle's (1995) paper was to report upon this latter phase of the study, but she notes that, whilst the nature of the ethical problems identified in the first phase are remarkably consistent, the answers provided by participants in the second phase are extremely varied. Oberle comments that perhaps the most significant finding in the study was:

> ...an astonishing lack of agreement among faculty members regarding the quality of the written responses for each scenario. The inconsistency and widely differing viewpoints made it impossible to develop a 'best' response upon which faculty members could agree...Responses placed in a 'best' category by some faculty members were placed in a 'worst' category by others.
> (Oberle 1995:p307)

The inconsistencies occurred in a variety of ways, for example some faculty members accorded importance to the nurse's professional/institutional obligations, whereas others focused upon the patient/nurse relationship. Oberle argues that, if ethics theory fails to provide consensual solutions to ethical problems in practice, then course content, and methods of assessing moral reasoning, require to be re-examined. She identifies the problem that, within theories such as Kohlberg's, which suggest the possibility of measuring 'levels' of moral reasoning, there lies an implicit assumption that the level will remain constant irrespective of contextual change. This is not an expectation invariably borne out in reality.

An example from my own study of a 'change in level' over time occurred when one of the students, Sheila (Interview 25), discussed a child who had severe learning difficulties and physical problems and whose parents had made the decision to place her in a longterm care setting. Sheila said that, prior to commencing nursing, she would have been more judgemental about such behaviour and designated it as wrong *in principle*, whereas an awareness of the complexity of the situation in which the parents in question found themselves rendered her unable to make a universalisable statement as to the action which should, or should not, be taken.

Oberle (1995) suggests that extant theories have failed to provide an agreed-upon moral perspective for nurses and concludes, rather gloomily, that:

> Until such time as a satisfactory theory of nursing ethics has been articulated, one might presume that efforts at defining successful methods of teaching and evaluating nursing ethics will be doomed to failure.
> (Oberle 1995:p312)

The above conclusion is an illustration of the problems inherent in adoption of a modernist approach to ethics and morality, in which, unless one neat, all-encompassing theory can explicate all, then the result is chaos.

Vogel Smith (1996) emphasises the need to examine the experience of nurses, in order to explore their ethical decision-making processes, as opposed to using a pre-existing theory with which to categorise data. She interviewed 19 staff, asking them to describe an ethical decision[29] which they had made and the means by which this had been reached. Analysis of data revealed four common aspects of importance. The first, *context*, refers to the importance of the substantive conditions under which the decision was made. Within that, a stimulus, or *trigger*, which may be internal or external to the nurse, initiates identification of a problem, although this identification is sometimes only recognised as such in retrospect. Recognition is followed by *ethical decision-making*, a combination of the inter-related and inseparable processes of deliberation and integration. Personal and professional characteristics of the nurse are of importance, as is consideration

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[29]The ethical decisions varied from those which were of an everyday nature, to those fraught with conflict for participants.

of the perspective of others. Distance appears to facilitate the decision-making process, although it is not an absolute requirement. Integration involves incorporation of the decision into the substantive clinical context. The *outcomes* refer to evaluation of, and reflection upon, the consequences of the action taken. Vogel Smith (1996) concludes that the overall description of ethical decision-making that emerges from her study indicates the presence of much more wide-ranging and complex processes than those permitted by a justice/care focus, the implication being that, "...more nurses be given the opportunity to describe their ethical decision-making efforts, so that a full and accurate picture can be developed" (p24).

That context is identified as being of importance in order to set the scene highlights its centrality to any decision-making process. That distance is found to facilitate the decision-making process highlights the difficulty of making decisions in contextual situations. Whilst distance may be a useful and available tool for those whose encounters with patients are indirect, or fleeting, it is logistically problematic, if not unworkable, as a strategy for those, for example nurses, who, of necessity, have sustained contact with patients.

The student nurse experience

Kelly (1996) provides a synthesis of her two earlier studies (1991, 1992)[30], in order "...to examine, compare and interpret the perceptions of British and American nursing undergraduates regarding ethical nursing, or how nursing ought to be done." (1996:p36). Kelly found links between students in the two studies, both groups providing responses to the statement about 'good' or 'bad' nursing with similar substantive content in their accounts. The concepts of 'respect' and 'caring' emerged from the data, the former being considered to be the most fundamental nursing ethic, comprising respect for the patient in recognition of their individuality. The latter, caring, was associated with what the students described as 'little things', which again, acknowledges the patient as an individual. Students quite frequently utilised contrast, ie by description of care which they had

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[30]In both studies the participants who were interviewed were fourth year undergraduate nursing students. In the UK study Kelly (1991) n=12, in the U.S. study Kelly (1992) n=23.

witnessed and believed to be poor, in order to explicate care as it should be. One obstacle identified in relation to students' ability to live up to their own ethical beliefs was short-staffing and, consequently, insufficient time to deliver care to the standard they deemed desirable. Another was the pressure to conform to the standards (good or poor) set by the ward staff, a factor identifed by many writers, for example Melia (1981, 1987). Linked with the foregoing was the British students' perception of inflexibility of ward routines in some placements. The students' powerlessness and lack of self-determination caused frustration and moral distress in the instances in which concepts of respect and caring were, in their view, accorded insufficient importance.

The pressure upon students to conform to the placement ethos is one which students in my own study highlighted. When standards of care were high this was a positive, although sometimes daunting, experience but, in areas in which conformity necessitated students' compromising their own ideas of good clinical practice, it was problematic. The ramifications of this will be discussed in Chapter Four.

Joudrey and Gough (1999) carried out a study with the aim of investigating the ways in which student nurses construct ethical values. Following a pilot study, in which the researchers interviewed a small number of students, they were able to identify some of the issues deemed relevant by participants. They developed a questionnaire, based upon these issues and distributed this to second year students.[31] Participants answered ten questions and were asked to provide an extended explanation of their reply: Joudrey and Gough (1999) report on the answers to Question 10, which asks whether students perceive any differences between the ethical positions of nurses and doctors. Use of content analysis identified care and cure as major themes descriptive of the students' perceived differences between the former and latter. Some of the extended responses indicated not only that there is a difference, but that the care focus of nurses is superior to the cure focus of doctors. Joudrey and Gough speculate that this view may be an attempt to increase the self-esteem of nurses in the face of medical hegemony.

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[31]110 distributed: 66% response rate

Within my own study, this dichotomy between care and cure was unremarked, although the transient nature of encounters between medical staff and patients was highlighted. This was viewed as problematic by some students, in that the greater individualised knowledge of the patient possessed by the nursing staff, with whom the patients have sustained contact, was considered by students to be devalued by the medical staff. Also emphasised by students was the power possessed by the medical staff, in particular in areas in which application of sanctions under the Mental Health Act was an available option.

Joudray and Gough (1999) identify that it is not possible for them to generalise beyond the sample in their own study and that further research is required, suggesting the use of interviews to probe extant data and possibly a longitudinal study, in order to explore changes over time. A point of frustration for the reader is that Joudrey and Gough's account does not identify whether students had undertaken practice placement experiences at the time of their participation in the study. One does not, then, know whether students had witnessed the day-to-day behaviours of nurses and doctors as a foundation for their answers, or whether their comments were based upon their prior life experiences, including theoretical input from lecturers and exposure to media representation of health care workers. In identification of the sources of their ethical values, the students identify family, religion, peers and lecturers, but not clinical staff. (The possible reasons for an absence of practitioner influence are of interest, but are not remarked upon by Joudrey and Gough.)

A final comment in relation to Joudrey and Gough (1999) is that they make a greater acknowledgement than most of the fact that an ability to 'talk the talk' may, or may not, translate into 'walking the walk' and that there is the possibility that the former may consist in empty rhetoric.

Literature Review: Summary

It may be seen from a review of the literature that research studies into the moral reasoning of nurses have been based, for the most part, upon enduringly influential theories within the field of psychology. Kohlberg's theory of moral development supports the modernists' perception of history as progress, commencing from a standpoint of relative ignorance, but with the potential to uncover universal truths

and moral principles. Such principles are transcendent of context and predicated upon a belief that emotion and rationality exist as discrete entities within the individual. They place adherence to theoretical abstractions above and beyond concrete personal commitments and contextual awareness.

The focus within Kohlberg's assessment/evaluation criteria is upon the identifiable products (ie stages and levels), rather than the processes by means of which these 'snapshots' of moral reasoning achievement are attained. The charm of Kohlberg's theory for his adherents appears to reside in the security afforded by its apparent concrete embodiment of concepts which may otherwise appear ethereal, elusive and poorly-demarcated in terms of definitional boundaries. Identified criteria, and the development of 'tools' by means of which these may be measured and evaluated according to the canons of traditional science, have appealed to many with their promises of certainties, which are attainable by traditional, academically-respectable means.

However, it may be seen that some of those who advocate a different approach may replace the traditional grand theories with their own. Rather than transcending traditional assumptions, they may perpetuate the search for *one* theory which will explain all. Thus, a theory which proposes an all-encompassing ethic of 'justice' is replaced by another which proposes an all-encompassing ethic of 'care'.

The literature review has identified that the work of Kohlberg and Gilligan has provided an influential foundation upon which researchers into the moral reasoning of nurses have constructed their own studies. Within Chapters Four and Five I shall further situate the literature review in relation to the findings from my own study and shall argue that moral decision-making is of greater complexity than can be encompassed by any single theory.

Chapter Two reviewed the theoretical and empirical work of relevance to my intended area of study and indicated appropriate (and possibly inappropriate) approaches to data collection and analysis. Chapter Three provides a discussion of methodological issues and an explication of the research methods used within my study.

Chapter Three

Methodological issues and procedures

It would seem a prerequisite that approaches to research design be determined by the research problem, or area under investigation, a point emphasised by, amongst others, Morse and Field (1996), Melia (1996) and Coffey and Atkinson (1996). Coffey and Atkinson (1996) argue against adoption of a single approach to theorising and emphasise the need for active engagement of the researcher with the data in order to speculate and to test ideas (p142). Whilst they reiterate the need for all approaches to be systematic, reflexive, iterative and clearly explicated, in order to demonstrate rigour, they argue that there should be no requirement for researchers to commit themselves to production of only one kind of idea, or for dependence upon only one theoretical perspective (p145-6).

The literature describing nursing students' own accounts of their experiences, feelings and perceptions in relation to the patient/client care which they encounter during their practice placement allocations is relatively scant. As this was the area of interest for my study, it appeared that a qualitative approach was appropriate, to enable emphasis to be placed upon the perspective of the participants in the research. This should facilitate insight into the meanings that the students ascribe to events and experiences and indicate the processes which determine their response to these events.

Morse and Field (1996:p2) describe the use of qualitative research to explore problems about which there is little information, the overall purpose being the construction of a systematic and credible explanation of a situation, which may then be used to guide knowledge development. The task for the researcher is to provide a framework within which respondents can convey an in-depth and accurate account of their personal perspective in relation to the area under study (Patton 1990:p24).

The foregoing authors emphasise the importance of an open-minded approach on the part of the researcher. Whilst one's prior knowledge, assumptions and preconceptions cannot be obliterated (even if this were considered desirable), it is important that these, and the effect which they may have upon the research

process, are identified, in order to minimise any adverse impact upon the study's findings.

The role of the researcher in the research enterprise

Coffey (1999) argues that, whilst many qualitative researchers and the authors of methods textbooks identify the role of the researcher in the construction of the research process, they nonethless tend to,

> ...confine the discussion of the personal and the emotional to particular aspects of the research process, rather than establishing them as pervasive to the whole enterprise.
> (Coffey 1999:p3)

Coffey (1999) uses the works of Lofland and Lofland (1995), Hammersley and Atkinson (1995) and LeCompte and Preissle (1993) to illustrate her argument, as these are widely accepted within the UK as being 'gold standard' methods' texts. Coffey (1999) argues however that, "A brief analysis of these [texts] reveals the simultaneous presence and marginality of the researcher self" (p2) and that this approach, "...fails to acknowledge the complexities of identities, roles and relationships that can characterize fieldwork" (p5). The idea conveyed within such texts is that the researcher's identity requires to be manipulated in order to facilitate the research process and product, but Coffey argues that this approach omits identification of the effects which fieldwork has upon the identities, relationships and emotions of *all* participants (ie 'researcher' and 'researched'). Coffey's (1999) insistence on an explicit recognition that researchers, accompanied by their epistemological and conceptual baggage and concomitant life experiences, permeate and suffuse the entire research enterprise, represents a view which has gained increasing momentum in recent years.

Sword (1999) writes that,

> Although some would criticize the subjectivity that is inherent in interpretive work, no research is free of the biases, assumptions, and personality of the

researcher. We cannot separate self from those activities in which we are intimately involved.
(Sword 1999:p277)[1]

In writing the thesis I have used the third person when describing and discussing an existing theory, or the work of other writers, but the first person when referring to my own interpretation of these works and also in the description and analytical comment in relation to my own study. As Webb (1992) writes,

> The notion of objectivity in research is conveyed by the use of the third person in academic writing...this form of language conveys, and is intended to convey, an impression that the ideas being discussed have a neutral, value-free, impartial basis. Its universal use in academic writing is not justified unless the material being presented is in fact underpinned by these qualities.
> (Webb 1992:p748)

As neither the area of interest selected for my study (student nurses' perceptions of patient/client care), nor the method (interviews with the students, which involved social interaction within a given framework), nor the analysis (which entailed my own interpretations of interview data), can be said to be objective in any sense of my being in some way external to the processes and product, it would be misleading and counter-productive to the credibility of the study to present these aspects in the third person. Porter (1993) argues that,

> Avoidance of the first person is not a trivial habit: it is a reflection of a number of profound theoretical assumptions...[which have] linked usage of the third person with the idea of objectivity.
> (Porter 1993:p138)

He points out that, whilst reform of literary conventions will not, per se, improve veracity, it is necessary to accept that the person of the researcher is integral to the production of research findings and that the use of the first person at least signals an explicit awareness that this is the case (p142).

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[1]The relationship of these comments to my own study will be identified and explored in greater detail in Chapter Four.

Use of the first person, and consequent acceptance of myself as an integral part of the research process and product, does not suggest that the study, or conclusions drawn, lacked rigour and this is verifiable by a clear explication within the thesis of all decisions and analytical comment made and the foundations upon which these were grounded.

Having identifed that a qualitative approach appeared appropriate for my own study, it should be noted that Atkinson (1995:pll9-120) writes that, within what is identified by some to constitute a qualitative paradigm, diversity is a distinctive characteristic. No single set of theoretical or methodological criteria provides a keystone for a qualitative paradigm and the lists of 'acceptable' methods and exemplars cited vary from one author to another.

Leininger (1985, 1992) and Baker et al (1992) advocate a purist approach and avoidance of 'method slurring', their rationale being that mixing methods diminishes or destroys the integrity and validity of the research because the philosophical origins and desired outcomes of research differ. Although Leininger primarily opposes mixing of quantitative and qualitative methods, rather than the selection of more than one qualitative approach (unlike Baker et al, who oppose mixing of qualitative methods), she states the importance of particular methods being implemented as explicated by their original creators (1992:p404). This prescriptive approach to research design is refuted by Morse (1992a:p259-260, 1992b:p4), who emphasises that theories are tools which should be used as a means to an end and not as ends in themselves and that they are not fixed, unchanging entities, but subject to revision, reconstruction or replacement. Atkinson (1995:pll8-ll9) warns that, whilst a concrete, summarised and neatly-boxed view of methods, strategies and paradigms may aid initial teaching of research to students, the realities of the research situation are that high levels of uncertainty may require to be tolerated. He identifies the danger of allowing a 'textbook summary' approach (prescriptively) to guide the conduct of original research and points out that in practice it is rare for researchers to confine themselves to narrowly-defined methods (pl22), a point which has remained pertinent over time (cf Schatzman and Strauss 1973:p7).

The fact that adoption of a rigid and prescriptive view is undesirable, by no means indicates that 'anything goes', and the authors who advocate a flexible approach

to methods and strategies all emphasise the importance of the researcher clearly explicating decisions, and the rationale for these, in all aspects of their study.

One criticism which is frequently directed at qualitative approaches is that they lack the 'scientific' rigour and credibility associated with traditionally accepted quantitative methods, in which inquiry is assumed to occur within a value-free framework and which rely on the measurement and analysis of causal relationships between variables. That quantitative approaches are indeed objective, impartial and value-neutral has been questioned by a number of writers, for example, Sandelowski 1986, Guba and Lincoln 1989, Mishler 1990, Denzin and Lincoln 1994) and the idea that the criteria for evaluation of quantitative material (ie reliability and validity) are appropriate in identical format for evaluation of qualitative research is similarly debatable (Sandelowski 1993, Guba and Lincoln 1989, Mishler 1990:p4l6, Strauss and Corbin 1990, Webb 1992, Koch 1994, Anderson 1995, Morse 1999a, Popay et al 1998).

A grounded theory approach

The foregoing discussion has focused on the need to avoid approaches which may, by zealous adherence to specific tenets, inhibit or constrain the research process. In relation to my own area of research interest, a major requirement of the method selected was that it would permit the data obtained from the students to drive, and indeed dominate, the agenda for the study's subsequent direction. I also felt that my lack of experience as a researcher precluded the degree of flexibility proposed by Coffey and Atkinson (1996:pl45-6) and that my own study necessitated the use of an extant guiding framework, the appropriateness of which would be subject to ongoing scrutiny. It appeared to me, from extensive reading around a variety of research methods, that the strategy for designing, conducting, analysing and theorising (Atkinson 1995:pl22) suitable for use in my own study was that provided by grounded theory, so called because theory is generated as a result of the concomitant collection, coding, comparison and analysis of data (Glaser and Strauss 1967:p43). Any theory development is thus 'grounded', or based, clearly and identifiably upon the information within the data set.

Grounded theory was first described by Glaser and Strauss (1967) and has been the subject of further explication (and polemic) since then (Glaser 1978, Strauss 1987,

Strauss and Corbin 1990, Glaser 1992). Strauss (1987) states that grounded theory is neither a specific method nor a technique, but is rather a style,

> ...that includes a number of distinct features, such as theoretical sampling, and certain methodological guidelines, such as the making of constant comparisons and the use of a coding paradigm, to ensure conceptual development and density.
> Strauss (1987:p5)

Glaser (1992:p34) additionally writes that use of a grounded theory approach is suitable for areas in which there is scant literature or research.

Theoretical orientation of the study

Symbolic Interactionism

The theoretical orientation underpinning grounded theory is that of symbolic interactionism, an interpretation of social psychology first described by Mead (1934, 1964). Blumer (1969) provided a further articulation of Mead's perspective and describes symbolic interaction as being based on three premises. The first is that people will act towards the things/people that they encounter in a manner which accords with the meaning that these things hold for them and the second is that the meaning which things hold is learned and developed from the social interactions that humans have with one another. The third premise is that these meanings are processed, interpreted and subjected to review and possible modification by the person encountering them. Individuals may then be viewed as being active participants in creating meaning in any given situation.[2] Symbolic interactionism studies people on two levels, firstly by observing interactional behaviour in a given situation and secondly by analysing the symbolic meaning of that behaviour.

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[2] Of course, being an active participant in creating meaning in any given situation does not necessitate being 'active' in the construction, or deconstruction, of structural constraints: only that participants have the ability to create meaning out of the conditions which prevail.

Interactionism has been criticised on the grounds that it ignores the wider societal frameworks within which individuals must operate and which may constrain, or facilitate, their abilities to act as free agents. This criticism is only justified if it is the case that interactionists are sufficiently naive to assume that issues outwith the immediate situation do not impact upon interaction between agents.

Some of the literature appears to operate upon the assumption that explanations are either structural, in which case the individual is acted upon, as opposed to being free to act, or alternatively, are interactional, in which individuals are unconstrained free agents, whose ability to act is uninhibited by the framework and structures of the society which they inhabit. I shall follow the argument that such dichotomies are neither helpful nor necessary, and that an interactionist approach, not only does not preclude, but indeed allows, adequate recognition of structures which are external to the individual. It is, of course, arguable whether it is possible, necessary, or desirable, to attempt to construct any *one* explanatory theory which accounts for the complexities of social life.

Within the thesis, then, whilst the analysis will focus upon the interactions of individuals, this will be situated within the wider arena which impacts upon, and extends beyond, the substantive situations in which the students found themselves. One writer who has provided an account of the influence of structures upon the agency of the individuals who operate within them, is Goffman (1974).

Frame Analysis

Goffman (1974) provided a study of frames, based upon his assumption,

> ...that definitions of a situation are built up in accordance with principles of organisation which govern events - at least social ones - and our subjective involvement in them: frame is the word I use to refer to such of these basic elements as I am able to identify.
> (Goffman 1974:pp10-11)

Goffman's aim was to move beyond study of the interaction of individuals on a substantive level, to a generalisable theory about the fundamental properties applicable to all frames within which individuals may operate. He proposed that identification of universal properties would facilitate subsequent understanding of

the options which are accessible and inaccessible to individuals and, additionally, the extent to which the actions of individuals may alter, without fracturing, the frame itself. Although grand theories are demode within a post-modern approach, discarding them on this basis alone is unreasonable . Indeed, following the post-modernists' argument that each and every account of experience is, in its own way, as valid as any other, there seems no requirement to exclude the relevance or application of grand theories out of hand. It would seem necessary, however, to treat them with caution, as it is arguable that the complexities of culture, time and context (both in relation to the individual who develops the theory and to those to whom it is then applied) render universalisable grand theories problematic.

In *Frame Analysis* (1974:p13), Goffman states that it is his intention to write about the organisation of experience of individuals, rather than the organisation of society as a whole, although it can be argued that the feasibility of dividing these into separate entities, even for the purpose of analysis, is questionable. According to Goffman, the organisation of individual experience into different primary frameworks renders what would otherwise be meaningless aspects of a scene into something which is meaningful to the actors within it.

The primary frameworks of a social group constitute a central element of its culture, resulting in (and creating) shared understandings amongst its members (Goffman 1974:p27). The use of frames assist individuals in their identification of behaviours which are permissible and those which are not (p205), within that particular frame, thus facilitating smooth and predictable social interaction. The activities which demarcate in-frame activities from those extraneous to it are also indicators of the ways in which the activity within the frame is connected to the surrounding world (p249).

Equally, within a frame, a discrimination is usually made between the individual as they are within it, and what might be referred to as their wider identity ie that which would pertain within the other frames within which they operate. So, for the participants in my own study, this would involve differentiating between their identity as a nursing student within the framework of their practice placement allocations, their identity as a student within the framework of the university, their identity as research participant within the framework of the interviews and their differing identities within a variety of other frameworks. As Alasuutari (1995:p

111) points out, "...when a frame changes from one into another, so too do the situational identities of the participants change." This, then, has the potential to engender uncertainty in those who are placed in frames with which they are unfamiliar. Although Goffman argues that the frame provides guidance for the individual as to behaviours which are, and are not, acceptable within it, and is thus facilitative of social interaction, the individual may experience conflict, either because frame activity does not meet their expectations and they do not wish to comply with its requirements, or because they are unable to do so.

Gonos (1977:p857) writes that, although Goffman is frequently associated with symbolic interactionism, his writings involve attempts to go beyond the unfolding of everyday events to the structures which govern our behaviours within these and that this is a structuralist perspective. Gonos (1977:p858) cites Goffman (1974:p127) as stating that, "The first issue is not interaction but frame" and, whereas a situation is of necessity described by the factors which are specific to it, a frame is described by the stable rules which govern its operation, irrespective of substantive content (Gonos 1977:p857). Goffman regarded the idea of continuous construction and reconstruction of perennially occurring social activity, such as is entailed by a purely interactionist approach, as infeasible and visualised frames as the cultural resources utilised by individuals in their daily interactions. The adherence of individuals to these extant conventions reinforces their usage over time and, although not inviolate, frame structure, unlike that of the content of substantive situations, remains stable and its essential features constant over time. Despite Goffman's interest in the structural attributes of frames in a very general sense, his discussion takes place at a high level of abstraction and he provides scant analysis of specific frames.

Relevance of Frame Analysis to the study's findings

The nursing students within my study accorded considerable importance to the role of *individual* care-providers within the practice placements. Particular importance was accorded to the personal attributes of the person in charge of the placement area.[3] This individual was viewed by the students as being the main

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[3]The person in charge was invariably a registered nurse during the students' first four placements. For students who had selected Learning Disability as their Branch programme, the person in charge in some Branch-specific placements was

determinant of the quality of care provision, although even in early interviews some of the students' comments indicated an awareness that the individual was not entirely a free agent and that constraints outwith their control might influence their abilities and consequent behaviours in relation to others. In later interviews this awareness appeared to be more acute, in that it was more clearly explicated within the students' accounts, and in the final interviews with the students, immediately prior to completion of their three year programme, the organisational framework was identified as being a cause for personal concern, ie as something which might well impact upon their own ability, as registered nurses, to provide the quality of care which they thought desirable. This identified tension between the freedom of individuals to act, irrespective of the framework, and the constraints upon action exerted by the organisational framework within which care was delivered, is thus subjected to examination and exploration within the chapters which analyse the study's findings.

Structuration theory

Giddens (1984) proposes that neither interactionism, nor structuralism, stand alone and in consequence develops a theory which aims to combine elements of both and thus provide a more comprehensive sociological explanation of human behaviour. This concept, which he named structuration, proposes that, with few exceptions, individuals possess the freedom for action, but he does provide a concomitant acknowledgement that structures exist which may inhibit or facilitate action. These structures however exist only in, and through, social action (and thus are vulnerable to modification, if not destruction). Giddens argues that structure and action are two sides of the same coin and thus have an integral, intimate and indissoluble relationship which precludes the independent existence of either. He states that the symbiotic nature of their relationship entails that structures enable social action to occur and, concomitantly, social action creates (and sustains) structures.

Giddens' conceptualisation of structures is two-fold, comprising rules and resources. Rules may be written or unwritten, whilst resources may be allocative, or authoritative. The former type of resource refers to objects, for example use of

a social worker.

agricultural land to cultivate crops, whereas the latter resource refers to, for example, the power which may entail utilisation of humans as a resource.

Agency, the other side of the coin, involves human action (or inaction). According to Giddens, humans have a requirement for a degree of predictability in life, in order to provide an ontological security, and it is this, coupled with culturally shared knowledge, which regulates social life. Patterns of behaviour create and sustain structures, social systems and institutions, which form the medium by which human action occurs but, inherent within all this, is the potential for change. Giddens argued that, if sociology is to progress beyond dichotomous conceptions of action and structure, then studies are required in order to identify the means by which structures are created and replicated. One of the criticisms of Giddens (cf Craib 1992) is that he has carried out little in the way of empirical research, preferring to construct 'grand theories' in the absence of substantive corroboration. Craib's overall criticism of Giddens is not that he considers his analysis to be wrong, but that it is partial and wrong insofar as it claims to be comprehensive and all-encompassing (Craib 1992:p130).

Whilst Giddens' ideas are of interest and possibly provide a more comprehensive view than a focus on either structure or agency in isolation permits, his theory emphasises the role of agency to a greater extent than is perhaps justified. He states that freedom of choice is almost always available for individual agents and that 'actual' compulsion is rare, being confined to situations in which one is *physically* unable to make a choice. Although his ideas here appear to have links with existentialist notions of freedom, it is arguably simplistic to focus upon the relatively obvious physical constraints upon freedom and ignore, or diminish the importance of, the psychological, sociological and moral inhibitions and sanctions which may exist, even although their physical observation is not possible. The applicability of the ideas of Giddens will be later examined in the light of the students' narratives, as the latter had much to say about the extent to which the individual vis à vis the organisational framework within which health care is delivered impacted upon the quality of care which patients and clients received.

Theoretical Sampling

In relation to selection of data sources, grounded theory entails the use of theoretical sampling (Glaser and Strauss 1967:p45-77, Glaser 1978:36-54). This involves determining one's next source of data from the information obtained hitherto by the joint processes of collection, coding and analysis of data. What are not made explicit however are the criteria which should be used for selection of the initial sources of data, a problem highlighted by a number of writers, for example Reed et al (1996:p55). Glaser and Strauss (1967) confine their guidance to saying that,

> The initial decisions for theoretical collection of data are based only on a general sociological perspective and on a general subject or problem area...The initial decisions are not based on a preconceived theoretical framework.
> (Glaser and Strauss 1967:p45)

Morse (1991:p127-145) suggests that this may involve obtaining data in the initial stages from those who have a broad general knowledge of the topic, or have undergone experience which is thought to be typical.

Sampling strategy[4]

Within my own study the initial student participants constituted a *purposive* sample, as described by Silverman (2000:p104), the aim of which is to obtain information from those who are well-placed to provide it. This, then, could have included any student who had undertaken a practice placement. My initial sampling decision was based upon the *situation(s)* in which the participants were placed, as opposed to their demographic 'representativeness' as members of a student group.

In the first instance, I carried out individual interviews with three students who had completed at least eighteen months of their three year programme, on the

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[4]This section provides the rationale for the sampling *strategy*. Later sections will provide details in relation to recruitment, ethical issues, interviewing procedures and data analysis.

grounds that they had gained considerable practice placement experience. I asked the students open-ended questions about their allocations, with specific reference to the client care that they encountered. The purpose of these three interviews was two-fold:

- to generate information about issues of importance to students in practice placements, in order to provide a foundation for future interview agendas
- to obtain experience in interviewing, both in relation to questioning and listening techniques and in the use of recording equipment and transcription of data.

The initial three interviews fulfilled the above purposes and I subsequently recruited seven students who had completed two placement allocations (each of five weeks duration), in order to obtain their perspective.

Whilst my original intention was to carry out individual, single interviews with a larger number of students, my data analysis following the first interviews with these seven students suggested that interviewing them at a future date would be a more appropriate method of obtaining rich data.[5] The rationale for adoption of this strategy is illustrated by data from *one* of the students, Alan, although there were instances from *all* students to indicate that exploration of their subsequent placement experiences would be profitable. During my first interview with Alan, he described an instance of what he termed bad practice, but said that he had felt unable to vocalise his concerns whilst undertaking the placement:

> ...I should have said something, but I didn't...You're afraid to speak up you know...you want to say something, but you have to bite your lip...in case I got a hard time...Bad assessment at the end, you know?
> (Interview 6:p 9)

This is *one* example of data from the first interviews which stimulated an interest in pursuing the *same* students' perceptions and responses during later placements. On the basis of such data, I decided to interview students on a second occasion, eighteen months into their programme, by which time they had undertaken two, for some students three, further placements.

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[5]Appendix Two provides the dates, and stages within the three year programme, at which I interviewed students.

On the occasion of the second interview, part of my agenda in Alan's case was to ask him about his response, if he described a similar incident to that discussed in the first interview. Alan cited situations in which mechanical hoists should have been used to assist in the movement and handling of patients, but were not. I asked about his reaction and he said that he felt unable to suggest that use of the equipment was appropriate because:

> I think I would only feel confident in suggesting things like that, when I was qualified, you know? You just [pause] you're feared in case what you say is - you're put down to a sort of trouble-maker [half-laughed]. So, you just really go along with it, the flow.
> (Interview 11:p 3)

During the same placement, however, one of the staff swore at a client who had learning difficulties and, although Alan did not challenge the individual directly, he felt that:

> I *should* have, you know, it's - I feel bad about that you know. But, thereafter, I *did* report it to the ward manager, but whether anything gets done, I don't know.
> (Interview 11:p 13)

It may be seen that this data represents a slightly different response from that in the first interview. Data analysis identified changes and constancies in the students' perceptions and actions, in addition to identifying substantive codes and categories within the data. The decision was thus made to interview the same students at the beginning of their third year.

During the third interview, when Alan identified that he now felt able to *assess* individual patients' needs and abilities *prior* to implementing care (and was critical of some staff for not doing this), I asked:

> Dorothy:
> I know in the previous placements you were at, you said that one of the reasons you didn't speak out, obviously, was because of things like your assessment [A: sighed] and fitting in and stuff? Does that?

Alan:
No. That doesn't bother me now, no. I mean, I've passed on, if there's something I wasn't happy with, I wouldn't care. If they gave me a bad report, I'd just go to the college and I'd just say, eh, "I think this is a personality thing, you know". [D: Yeh] Coz I've been getting good grades all the way through and, if I'm getting bad ones, well, you know? [shrugged] [D: Yeh] No, I wouldn't be afraid at all now.

Dorothy:
So, what do you think's given you more confidence then? I mean, I'm just interested?

Alan:
Aye. I don't know. I don't know if it's a feeling, "I've had enough"...I mean, you seen bad practice and you think, "Why should people be taking this?", you know? I mean, if that was me [pause] lying in that bed, getting that standard of care, I wouldn't be happy, so [pause] I mean, that's the way I view it...you just get to a stage, you just get fed-up, seeing bad practice and [pause] just your actions getting nowhere, you know, so you just, it's just, you try to get things improved, you know?
(Interview 17:pp12-13)

There are obviously a number of issues of interest within the above data and these, along with the data from the other interviews, will be discussed and explored in detail in Chapter Four. The purpose of providing examples of data within this section is to illustrate the way in which they informed the direction taken in relation to sampling. Whilst one alternative to the method I adopted would have been to carry out a cross-sectional study, with the aim of generating more *diverse* data, such an approach would have precluded the possibility of tracking changes and constancies in individual students' accounts over time.

It was, then, data analysis, by the constant comparative method which is a central feature of a grounded theory approach, that dictated the potentially profitable sources for data collection. Thus, whilst the rationale for selection of the initial group of participants was *purposive*, the subsequent driving force was *theoretical* sampling, ie selection of future data sources based upon theory generated by analysis of existing data, with the purpose of pursuing theory development.

In relation to the self-selection of participants, it is necessary to emphasise that there was no attempt made to include, or exclude, students on demographic grounds, as it was not my purpose to select a sample which would be

'representative' of the group in this way. Indeed, the students in the study were not *demographically* representative, one example being that more men than women participated, despite the fact that, within the group of students who were approached, women outnumbered men by 5:1. Whilst this finding may be of interest in itself, it is not my intention to pursue it here because, as was stated earlier, my purpose in sampling was to access individuals who were in a position to describe their experiences within, and perceptions of, practice placements within the Diploma in Nursing course. All students who participated in the study were well-placed to provide this.

Interviewing and the use of narratives as data

The data within this study were generated by means of in-depth interviews with a small number of students. There is much in the literature which relates to the use of interviewing in qualitative approaches to research (eg Chenitz and Swanson 1986, Morse 1986, Silverman 1993, Holstein and Gubrium 1995, Hammersley and Atkinson 1995). Hammersley and Atkinson (1995:p124) point out that insider accounts may be read, not only for what they tell us about the phenomenon under study, but also for what they can tell us about those who produce them (ie the researcher as much as 'the researched').

Narratives as data

In recent years the use of narrative accounts as an appropriate data source for theory development has increased. Atkinson (1997) attributes this popularity in part to the longstanding cultural emphasis within westernised societies upon the individual,

> ...supplemented by increasing contemporary preoccupations with the revelation of personal experience through confession and therapeutic discourse...predicated on the assumption that an interior self, that is, anterior to external evaluation, can be accessed via the interview [which] ...often carries with it connotations that the surface of the respondent can be probed, and that the personal, private aspects of 'experience' can be rendered visible through dialogue.
> (Atkinson 1997:p327)

It may also be concomitant with the post-modern view that one account is, in its own right, as good as any other and that the account rendered by participants in research is as valid as any interpretive account provided by the researcher.

Atkinson argues that narratives are no more privileged than other forms of data and that the use of narrative within a research study requires to be integrated within a systematic approach, as opposed to being viewed as a data source of unique, revelatory authenticity. In some instances, the researcher's expressed aim is empowerment of an individual, or group of individuals, who are perceived as being disenfranchised from the social or economic advantages enjoyed by more powerful groups. The means by which empowerment is to be achieved appears to be valorization of the narratives of the less powerful. In many of these, as Atkinson points out, there is,

> ...an extraordinary absence of social context, social action, and social interaction [and]...remarkably little sense of how narratives are forged in face-to-face interaction or how they are elicited in given social contexts. (Atkinson 1997:p339).

Atkinson argues that, being devoid of social context and, with no attention accorded to their formal structure, such narratives provide no basis for social analysis. Sociologists require to subject to scrutiny the means by which, within narratives, socially shared cultural resources are used in the production of comprehensible and convincing accounts of experience.

Similarly, Darbyshire (in Emden 1997) says that:

> ...There is nothing sacred or sacrosanct about people's voices. They are data that is [sic] material for interpretation...we need...to bring our interpretive energies and creativity and insight to bear on this thing called the data...The idea that somehow data stands alone, or speaks for itself, is so ironic. We used to criticize the positivists for doing that with statistics; you know, these are facts, these are figures, they stand alone; they are immune from any meaningful interpretation...this is a worrying trend, that somehow 'voices' – what people tell us – are completely unproblematic.
> (Darbyshire, in Emden 1997:p139)

Morse (1999b), writing in her role as editor of *Qualitative Health Research*, comments that some of the submissions received by the journal provide minimal synthesis of data, let alone analysis, in the belief that the participants' voices will

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speak for themselves and that any interference by the researcher will, in some way, diminish their authenticity. Whilst Morse comments that some of the journal's reviewers find this minimal level of reference to extant, or developed, theory acceptable, she is amongst those who do not. In her view, qualitative research must,

> ...add something more to the participants' words for it to be considered a research contribution, whether it be synthesis, interpretation, or development of a concept, model, or theory.
> (Morse 1999b:p163)

Mishler's (1990) perspective of the interview as narrative is as follows,

> I take it for granted that the account produced during the interview is a reconstruction of the past, shaped by the particular context of its telling. A respondent's re-interpretation of his or her work history is the basic 'text' for analysis and interpretation. The problem of 'distortion'...- that is, whether the account corresponds to the 'real' past - does not arise since I do not rely on a correspondence model of truth, where the earlier 'objective' reality serves as a validity criterion for what is being told now. This is not a weakness, but rather a hallmark of interpretive research in which the key problem is understanding how individuals interpret events and experiences, rather than assessing whether or not their interpretations correspond to or mirror the researchers' interpretive construct of 'objective' reality.
> (Mishler 1990:p427)

It is my intention, within this thesis, to adopt the approach identified by Atkinson (1999), which proposes,

> ...no special privilege for the collection of lives or the representation of voices. The biographical is one aspect of social life, biographical work but one way in which selves and identities are enacted. Narratives thus constitute one form among many of social representation. Viewed from this perspective, therefore, life-histories and personal narratives are themselves social products - subject to cultural conventions of style, genre and structure. Seen from this perspective, narratives are far from being transparent accounts of personal experience.
> (Atkinson 1999:p196)

Freeman (1993) says that narratives are not, in one sense, an inquiry into 'lives', but rather into the 'texts' of lives and that this precludes any sanguine assumption that narratives can provide a window on the world of the narrator (p7-8). Indeed,

what Freeman regards as the central feature of this process of *Rewriting the Self*, (the title of his book), is the means by which narrators confer new meanings upon the past in the light of the present, the experience of events being qualitatively different from subsequent reflection upon them. As such, however, they have the potential, by virtue of their reconstruction in the light of later knowledge, experience and reflection, to be used to attain forms of truth which may be unavailable within the heat of the moment (p224).

Another problem identified by Freeman is that, in recounting events, a simplistic assumption of 'history as progress' may pertain, and occlude the possibility of an acknowledgement of what Freeman terms the "existential dizziness" (p9) of the absence of an extrinsic meaning to life. He asks whether, indeed, we 'create' a point to narratives, where none in reality exists (p10). For the students in my study, the structure of their programme provides a framework which has the ability to produce within their accounts a sense of coherence and progression from their commencement as neophyte to emergence as qualified practitioner. This may result in an attribution or imposition of meaning to the account which may be misleading, or inaccurate. Additionally, the framework of the interview, which asks the students to reflect upon their experiences, may promote the idea of development over time where, in reality, none may exist.

Vitz (1990) argues however that, even in the absence of such a structure as the interview, or the organisation of an education programme, the tendency for humans to interpret even simple perceptual experience in terms of basic narrative categories is very strong and that, indeed, it is almost impossible not to think in this way (p711).

Perry (1981) points out that positions are by definition static, and the concept of development fluid, and that there are, consequently, problems inherent in using interview data, obtained at set points, as a basis for any analysis of transition and development. Perry indeed suggests the possibility that development is all transition and that 'stages' are merely resting points within that (p78). However, in my study, the 'stages' were the ones at which I interviewed the students and, although these were not arbitrary in the sense that they invariably took place subsequent to practice placement experiences, they were nonetheless imposed, rather than being points identified by the students themselves as being of significance.

Kaplan (1983) distinguishes between the notion of development and that of change over time, the former being a concept which refers to an ideal process of change leading to a goal or endpoint which is accorded value. As assumptions about the 'right' and the 'good' are inherent in values, any study carried out in relation to development will be subject to the researcher's own value system. Kaplan does not view this as problematic per se, but emphasises that the impossibility of value neutrality requires to be acknowledged.

The foregoing propositions are ones to which I shall return in Chapter Four, in the presentation of my study's findings. It is, however, clear that the substantive content of interview data, and the framework within which they are obtained, require critical examination and analysis. In writing this thesis, I am aware that the editorial licence which the researcher possesses enables inclusion, exclusion and juxtaposition of material in order to achieve a desired effect within the thesis, as a narrative.

There is, additionally, the tension which Tappan (1987, 1989:p302) identifies between participants' accounts of their own development and the theory used by the researcher to interpret the data. This creates a second text, which should also be the subject of interpretation and critical evaluation. In the construction of analytical comment within Chapters Four and Five, it is my intention to explicate clearly the supportive sources that I use.

Ethical considerations and access to students

Permission to access students for my study was granted by the Dean of the Faculty of Health Studies, following submission of a research proposal to the Research sub-Committee. As my study did not involve patients or clients directly, and as the students whom it was proposed to involve in the study would be volunteers, submission of a research proposal to an Ethics Committee was not deemed by the Dean to be appropriate. However, this does not imply that ethical considerations were absent either within the planning for, or execution of, the study.

I approached, in the first instance, a small group of students who had completed the Foundation Studies' component of the diploma, as I felt that it would be

helpful to obtain the perspective of two or three individuals who were at a more advanced stage in their programme than the students I intended to approach for the main study. I explained that I was carrying out research and that my area of interest was the students' perceptions and experiences of practice placement settings. I said that I was doing this by means of fairly informal discussions with students, of approximately 45-60 minutes duration, and that, whilst I would ask some questions, the student should feel free to do most of the talking. I explained that the interviews would be taped, in order that I could concentrate on what the student was saying and that I would then transcribe the tape verbatim, omitting any references to specifically named placement locations, staff or students. I assured students that their personal details would remain confidential and that the information which they provided would be anonymous, in that it would not be possible to link it with any specific student, staff member, or placement area. I provided the students with an opportunity to ask questions and then requested that anyone who was either interested in participating, or who wished to ask further questions, contact me and that we could arrange a date and time to meet. I emphasised that participation was purely voluntary and that students should feel no obligation to participate. I obtained three initial student volunteers in this way and we arranged mutually convenient dates and times at which to meet.

Subsequent to these three interviews, the data obtained were transcribed and analysed. I then approached a group of students undertaking the Foundation Studies component of the programme, with whom I had had minimal contact and provided the same preamble as previously. I requested that anyone who was interested in participating in the study enter their name on a copy of the class register which I then left within the classroom. My intention at this point was to carry out interviews with approximately five to seven students as a form of 'pilot' study, prior to interviewing larger numbers of individuals within a cohort. Seven students volunteered and interviews were carried out according to the format described earlier, although I had identified some areas of interest from the initial three students and wished to explore these, in order to see if the concerns raised were of similar significance to other students.

As explained earlier in this chapter, the use of theoretical sampling indicated that it would be more profitable to interview the same group of students on a number of occasions during their three-year programme, rather than undertaking a cross-sectional study. Once I had made the decision to request further interviews

with the same students, it seemed important to ensure that they did not feel pressurised into agreement. Because of this, I wrote to them, rather than making my request face-to-face, and emphasised that I was grateful for their contribution to date and that they should feel under no obligation to meet with me again, unless they felt happy to do so. All contacted me to indicate their willingness to participate.

During the course of the interviews throughout the study, there were a number of occasions on which students' accounts caused them some distress. This occurred, for example, when they described what they perceived to be mis-treatment of patients by staff, but which they had not formally reported. Clearly also, instances such as these were occasions of disquiet for myself, but I had, from the outset, indicated clearly to students that information about placement locations would not be sought, as my concern was to protect student anonymity. Given that the group of students within my study was small, this was an area of practical, rather than purely theoretical, concern. When such situations arose, the student and I discussed the options available, either within, or subsequent to, completion of the interview. As these discussions do not form part of the research study, per se, they are not reported upon here, except to identify that they were an area of concern.

Interviews throughout the study were carried out in one of the smaller study or class rooms within the university building and commenced with a brief reiteration of the information provided earlier and by my asking the student if they had any questions. The location for interviews was one which the students identified as being suitable for them, as they were undertaking college placements on the occasions on which we met. The names of all students within the study have been changed within this thesis, in order to preserve anonymity.

Interviewing

Silverman (1993:p94) states that, for interactionists, interviews are essentially about symbolic interaction and that the social context of the interview is therefore crucial in ascribing meaning to the data obtained. Many writers, for example Chenitz and Swanson (1986), Morse (1986) and Hammersley and Atkinson (1995), identify interviewer characteristics which may influence the manner, and possibly

content, of data collection. These include the age, gender, ethnic origin, status, openness, apparent integrity and credibility of the researcher in the eyes of the participant. The participant is also likely to observe the interviewer closely in order to determine whether the responses they provide appear to be appropriate and therefore it is important to ensure that the interviewer provides non-judgemental verbal and non-verbal responses, in order to confirm the acceptability of the participant's views. During the course of my own study, when students were re-telling events which they said did not reflect well upon themselves, their non-verbal communication seemed to indicate awareness of the possibility of being blamed for their failure to take what might be deemed 'appropriate' action. One example of this occurred during my first interview with Alan, when he spoke of being witness to the verbal and physical abuse of patients (Interview 6:p9). It was clear that he felt that the actions of the staff involved should have been reported and that his failure to do so, on the grounds that he did not wish to be seen as a trouble-maker and that he was concerned about the requirement to attain a good assessment, could be criticised. Situations such as these raised the dilemma for me of either sitting silently, or of making some form of response. Adopting the persona of the interviewer as 'objective' and impartial would no doubt have entailed the former option, but in recounting these events the students expressed, both verbally and non-verbally, disquiet and distress. Having encouraged the students to raise such issues, I felt a concomitant responsibility to interact as the situation required. Whilst attempting to maintain a neutral non-verbal response, my verbal comment in such circumstances was to the effect that it can be difficult for students to raise concerns and I then asked the student how he or she had coped with the feeling that they should have taken action and had not done so.

Whilst it is acknowledged that the factors raised by the foregoing writers in relation to interviewer characteristics probably did influence student responses within my own study, it is arguable that, given that this is inevitable, the most pragmatic course of action is to acknowledge and identify the extent to which the study's findings may be affected. That the area of study was the students' placement areas and not the university, meant that students were unlikely to feel that adverse comments made about care in placement settings would be unacceptable on the grounds that they reflected directly upon the university or its staff. Whilst I take on board the potentially inhibitory effect of having an 'establishment' figure as the interviewer, it has not been my experience, either

within this study, nor outwith it, that possession of lecturer 'status' precludes students expressing disquiet about their experiences, whether in university or placement settings, and that indeed they frequently do so.

Interview Agenda

My interview agenda was flexible throughout the study, as it was important to respond to the issues identified by *students*, in addition to pursuing areas which I deemed to be of interest. During the first interviews with the students, my introduction was general, but I used the introduction in subsequent interviews to raise issues which had emerged from the data analysis as being relevant. The following excerpts comprise my consecutive interview introductions with *one* student, in order to illustrate the format.

First Interview:

> Dorothy:
> I think I said a bit about what the research is about when I spoke to the class. And what I'm really looking to find out are what students' perceptions of their placement areas are. And the specific area I'm interested in really is, what the students think makes for good, or otherwise, nursing care or patient/client care.
> So, in general, what do students think about placements? You know, their perceptions of it and, then, thinking of what seemed to make for good, or bad, care in the placements you've been in?
> (Interview 9:p 1)

Second Interview:

> Dorothy:
> What I found particularly useful the last time we had a chat - I know you've got some stuff there to talk about [the student had brought some written points on a piece of card] was the fact that you brought up two contrasting examples; one was where the care seemed to you to be really good, where the nurse had taken it on herself to phone the Mental Welfare Commission because she was unhappy about a patient going home [Anne: That's right] And then, there was an example of when you didn't think things went so well, with that woman who seemed to be quite manipulative, who had the single room? [Anne: Uhuh] and somebody else was unwell and needed it and yet, she still got to keep it [Anne: Uhuh] because she made such a fuss. So, I did wonder if it was possible maybe to think again of examples where things seemed to go well and, then, not so well?

Anne:
Well, I've actually written down, in that format [indistinct, both speaking] of things, in that format.
(Interview 13:p 1)

Third interview:

Dorothy:
[talking as tape was switched on] So, really, what I'm interested in still is, what you think makes for good, or not so good, care. And I know the last time we met, you hadn't actually been to 'care of the elderly', so I don't know if you want to talk about that, or if you'd rather talk about what you've done in branch[6]?

Anne:
Well, I could do both...
(Interview 22:p 1)

Fourth Interview:

Dorothy:
One of the things I did wonder was, now that you're almost at the end of the programme, is, looking back, can you think that your ideas of what makes for good care have changed in any way over the time, or not?
(Interview 29:p 1)

When interviewing the students, I did not provide any overt indication as to my personal conception of the term 'care', phrasing my question instead along the lines of asking the students to identify factors that they considered made for good, or less than satisfactory, care, an approach which appeared to provide sufficient stimulus for subsequent discussion. No students attempted (nor were asked) to provide an explicit definition of their own conception of 'nursing care'. Rather, this emerged through their descriptions and, quite frequently, in their identification of work which, from their perspective, is *not* the remit of the nurse.

Of course, it is not the case that the responses from the students in my study were unfiltered by theoretical, media and personal constructions of care and caring and, equally, the many instances in which participants' perceptions were provided

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[6]ie Anne was undertaking the mental health branch of the three year diploma programme.

spontaneously does not accord them greater validity than those provided in response to a request (Hammersley and Atkinson 1995). However, it should be borne in mind that data from any group of human subjects is subject to some form of 'contamination' (as neither the researcher nor the researched come to the research interview in a vacuum) and it would appear more realistic, and fruitful, to acknowledge this, bear it in mind and continue, rather than pursue futile attempts to achieve an unattainable ideal.

As I wished to explore the students' perspective, the use of in-depth interviews, despite their attendant problems, seemed to offer the most promising approach. It meant that, by asking very general questions about the students' experiences in the first instance, I was able to identify and explore topics which the students raised as being of concern to them. Data generated in this way then directed the line of questioning, both within that interview, and within future interviews with the other students and with the same student at a later date.

The approach to the interview structure which I adopted throughout the study was that which is described by most writers as 'informal' and 'unstructured', ie although the date, time and venue were pre-arranged between myself and the students and although I had parameters for discussion in mind, the format was not pre-ordained, but involved providing a setting within which the students were enabled to identify and describe what they considered to be of importance within their practice placement experiences.

Swanson (1986:p66-78) defines what other writers refer to as 'informal' interviews as 'formal' (due to their pre-planned nature) but 'unstructured'. She identifies the problems, in relation to preconceptions and misconceptions, which are likely to exist if the researcher is herself familiar (in broad, if not specific, terms) with the research setting. In my case, I am a registered general nurse and familiar with the care of adult patients within a hospital setting. My preparation for practice was undertaken twenty years' prior to that of the students within my study, at a time when student nurses comprised an integral part of the workforce and when care delivery was organised in a different manner from most settings in the 1990s. Nonetheless, as placement link teacher[7] with responsibility for five adult care

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[7]The role of the practice placement link teacher is somewhat ill-defined and, consequently, problematic. The overall aim, however, is to allocate each lecturer

settings, I am <u>au fait</u> with current processes of care delivery and with the student experience.

The consequences of this degree of familiarity with the area under study, according to Swanson (1986), is that the importance of some data may be ignored or minimised by the researcher. An equally possible outcome is that over-emphasis may be placed on other data, or that some may be subject to misinterpretation. Whilst this is acknowledged, it can be argued that familiarity with the scene under study may have positive, as well as negative, outcomes. Not only may it provide a area of common understanding between interviewer and participant, but there is the advantage that a member of the institution who has worked within clinical areas possesses background knowledge which can be used to good effect and that, whilst this may blinker them in some respects, it may provide an enhanced understanding of other aspects, which would be denied a researcher who is a stranger to the area of study. It would, however, be inadvisable to make the assumption that, because the researcher has some broadly similar aspects of experience to the participants, they will thereby share the same understandings.

Concept definition:differing perceptions

An important point which emerged during interview discussions was that the meaning which students attribute to certain, seemingly familiar, terms is sometimes at variance with my own. The informal interview setting is important in facilitating exploration and clarification of the students'conceptions in a way that would be impossible to obtain by means of a questionnaire, or a highly structured interview agenda.

One example of the above was Anne's use of the term 'shortcuts'. She described a placement in which she said that care delivery had been of a high standard.

(all are registered nurses) to a number of the care areas designated as student placements. They then provide a link between the service and education provision for students within those locations, although the amount of time, and the nature of the support that they provide for students, is variable.

When I asked what she thought comprised care of this nature, she said that it included:

Anne:
...not taking shortcuts in care, em [pause]

Dorothy:
What do you mean by shortcuts there?

Anne:
Shortcuts? Um [pause]

Dorothy:
I mean, I've got an idea of what I might mean by that, but?

Anne:
Perhaps [pause] in the sense of [pause] well, hygiene perhaps. Em, making sure that when you take somebody to the toilet that, if their pad is a bit wet, that you do change the pad, if they've been incontinent. Rather than them saying, "Oh well, it's not really wet, that'll do". You know? Which I have seen, in other places. Um, giving people a bath and actually making sure that what they can't wash themselves, you take care of.
Instead of perhaps just leaving them in the bath and scooping water over the shoulders, which I've also seen....
(Interview 22:ppl-2)

On my initial hearing of Anne's use of the term 'shortcuts', it denoted perhaps assisting a client to wash or dress, for the sake of speed, when the client could have managed to achieve this themselves, albeit within a longer time frame. However, as can be seen from the foregoing extract, when I queried her own construction of the term, it comprised something rather different. There were a number of similar occasions during the interviews, in which the asking of clarifying questions prevented my making the error of assuming a common interpretation of a term. (Equally, of course, there may have been occasions on which I felt so assured of commonality that I did not question the meaning, and may have made interpretive errors as a consequence. In early interviews I operated on the assumption of shared meaning, but did experience concern that this might be ill-founded.) From Interview 8 onwards I explained to students at the outset that I might ask for their personal definition of terms which might appear rather obvious, but that the purpose was to ensure that I gained their perception, rather my own.

On other occasions, concept definition varied, not only between myself and students, but between one student and another. One example of this was in the rather different definitions of 'idealism' and 'realism', as used by George and Sheila. George, in reflecting on changes and constancies in his perceptions over time, stated that:

George:
...when we had the first interview, they [his views on good care] were a bit, kind of idealistic. And I think that now, having been working in the environment, I don't know...you see what, what good care is for different people. And, as my ideas become more realistic, they've become, I suppose, more individualistic as well [ie considering the client as an individual]...

Dorothy:
Yes. So, when you said you were kind of idealistic to begin with, how do you mean, 'idealistic'?

George:
Em [pause] in wanting to do everything quickly. And, I suppose when I first started as a student, when I was actually working on the ward, I was trying to do everything. I wanted to be super-nurse, you know, and I wanted to, to run round and be the one doing the dressing, the discharge, and the admission afterwards. And, em, I, I think I wanted to do everything for the person and didn't really em [pause] consider the time constraints that might be on me or them...I don't think that my ideas then were realistic...although I wished to do the kind of the ideal thing for the client, I think I, it was very kind of, perfectionist. And it was a sort of, well, I didn't take into account time constraints, I, I just wanted to do everything. [long pause] ...I was giving the care I thought I should give, as opposed to moving away and taking a back seat and saying, "What can you do to help yourself?" To the client. As opposed to me saying, "I'm going to do this, this, this and then this. And you're going to do A, B and C."
(Interview 28:pl-2)

I later asked George if he felt that the care that he provided, now that he thought that he was more realistic, was better that it had been when he was idealistic.

George:
Yeh. Yeh, I think because my, my idea was, I used to run around and be supernurse...I did everything...whereas now, I'm able to...devote more time to the people who need it. I suppose it's time management as well as, you know, ideas of quality care. [pause] And so I'm more able to manage my

time, so that I can spend an adequate length of time with each patient...I think I'm able to do that better now, than I did when I was running round doing everything for everyone...and you have to be quite honest with yourself and say, "Well, I'm not supernurse. I'm not perfect.
(Interview 28:p7-8)

It can be seen in this extract that George identifies idealism with his lack of experience of client care and an abstract conceptualisation of 'caring' as 'doing everything' for people, regardless of their requirement for such assistance. Idealism, for George, also entails a lack of awareness of constraints, such as those of time, which impose limitations upon care provision and necessitate prioritisation. Experience of caring for clients, observation of other members of staff as role models and reflection upon his own practice led George to what he perceived as being a 'realistic' position. This enabled him to take account of clients' individual needs and requirements and prioritise in care planning and implementation. In George's account the terms 'idealist' and 'realist' are both descriptions of himself, the latter position being viewed more positively by him than the former. It is also of note that acquisition of 'realism', in this conceptualisation, is resultant from increased experience, reflection upon practice and is associated by George with a higher standard of care provision.

George's definition of the terms differs in some aspects from that of Sheila, whose differentiation between idealists and realists was provided in her description of care within a community hostel, run by the social work department, for people with learning difficulties. She said that, within this placement, as compared with those which she had previously discussed, there were:

Sheila:
...*very* different approaches to care; very, very different.

Dorothy:
Did you think better approaches, or just different?

Sheila:
In some ways, yeh. In some ways they [social work staff] were more idealistic I think, than nursing staff. Nursing staff were probably more realistic, in some ways.

Dorothy:
Can you say what you mean by, sort of, idealistic?

Sheila:
I think em, the idealist view was very much into giving clients choice, which I do agree with. But, they were wanting to give the clients who really did not have the ability in some areas of life, to make choices...
(Interview 19:p16-17)

Sheila cited one client as an example. The man had learning difficulties which precluded full insight into the problems which his alcohol intake could cause. Some staff considered that limits should be set upon the amount of alcohol that he drank (the realists), whilst others (the idealists) felt that it was the client's right to drink as much as he wished, without imposition of limits, and regardless of the consequences for the client or for the other residents. Sheila felt that what she termed such idealistic views were only operable in the abstract, as they failed to acknowledge the complexity of the situation in reality, or to account for the possible ramifications for those concerned and that a realistic approach, which accorded recognition of these, was necessary. Sheila also felt, however, that, whilst she remained a realist, contact and discussion with idealists was mutually beneficial.

The foregoing excerpts have been used to illustrate the point that seemingly familiar terms may be accorded different shades of meaning and that this creates challenges in relation to data analysis and interpretation. Assumption of shared concepts may indeed be greater when the researcher has prior knowledge and experience of the general area under study, although this drawback requires to be weighed against the advantages, which are that areas unrecognised, or unappreciated as important by an 'outsider', may be explored. Whenever possible, whilst attempting to avoid requests for clarification to the point of pedantry, I tried to ascertain the students' construction of concepts, as opposed to superimposing my own. The opportunity afforded within informal, relatively-unstructured interviews to ask the participants clarifying questions, in an attempt to ascertain their meaning, is one of the strengths of the method. Within my own study it provided richer and more complex data than would have been obtainable by means of a questionnaire, or interviewing using a rigid agenda.

In addition to ascertaining the student's interpretation of a concept, as opposed to assuming my own, clarification of the student's meaning was facilitated by asking further questions, when this seemed appropriate. One example of this was when Anne discussed her experience in caring for people who had learning difficulties in

conjunction with physical disabilities. Her placement was within the day centre at the institution, but staff were sometimes sent to wards to provide assistance at residents' mealtimes:

> Anne:
> ...There was a fairly severe group, who can't use utensils and that, you know, there's a need for you to go and help them with their eating. But they call this 'feeding' you know,...it's like feeding time at the zoo when you're using this, these kind of words, you know?...

> Dorothy:
> What was it about the term 'feeding' that you didn't?

> Anne:
> I, I don't know, it just [pause]

> Dorothy:
> I mean, I could see reasons why you wouldn't like it, but I'm interested in what you're?

> Anne:
> I, just the term, 'feeding'. It wasn't, it wasn't [pause], it wasn't, "We're going over to help at mealtimes", which is the same thing. Em, it, it, was "*Feeding*", like, like you were throwing out food to people, well, not people, but [pause] you know, less than human beings? You, that was the image that I got.

> Dorothy:
> Depersonalised?

> Anne:
> *Yes*. Yes, very depersonalised. And specially because, um, talking to patients, they, as you were giving them their meal. It, it didn't seem to be the accepted thing. It was kind of, "Hurry, hurry". And the staff nurses said, you know [ie to Anne], "Jimmy, I'm sorry you've got Jimmy to feed. He always takes such a long time"...It was the kind of, the hurry, you know, to get it over and done with and yet, you, your meal, as you're eating, you know, you're not tot[ally], you know, shoving it in, drinking and then out the door, are you? You sit down, you speak to people, you have a sip of a drink...
> (Interview 13:p7-9)

Similarly, when Sheila was talking about her placement experience in a medical ward:

> Sheila:
> ...A lot of them were quite elderly and a lot, there was a lot of bedbaths, a lot of folk immobile, em, a lot of patients totally staying in bed for the whole time...So, the morning routine was very heavy you know? Em, a lot of very heavy-going patients who were very immobile. Um [pause] I don't know, I just [sighed], I just felt there was no meaningful interaction with the patients, you know, and

> Dorothy:
> Uhuh. What do you mean by 'meaningful'? I'm just interested in how you'd define 'meaningful interaction'?

> Sheila:
> Yeh. In terms of, you didn't really get to know them. And there was no chance for them to say how they felt about any of their procedures. You know, if they called they really had to shout for ages for somebody to get attention. And the ones that didn't shout, you know, were left there, you know? And there was a rare occasion when you got to give somebody a bath and I ended up always trying to make sure I got giving the patient the bath, you know, so that I could get some time with them [laughed]...

> Dorothy:
> And that's a theme that comes up quite often, that people feel that the only way they can actually communicate with patients is if they manage to shut themselves off, supposedly doing some physical task, that *justifies* spending time [Sheila: Yeh] with the patient.

> Sheila:
> Yes, that was it. You couldn't just go and sit and talk with a patient in the afternoon. Like, for example, I really felt for some of the patients that never got any visitors, during visiting time, you know?...You know [pause] I don't know, if nursing's like, the whole person, you know, it [ie the care on the ward] just wasn't. And, even talking to somebody in the bath, I mean they're naked before you in the bath. I mean someone might be, you know, especially the fact that they're male and you're female, you know, feel a bit. So, it's not necessarily the best place for, you know, communication, you know? Em, so [pause], I thought it was very depersonalised, the whole process, so, so depersonalised. My mentor was actually leaving because, you know, situations like that...
> (Interview 14:p6-7)

These particular examples are cited, not because they are unusual in eliciting an extended response from the students concerned, but rather, are typical in that they

achieve this. The data thus obtained enable an analysis to be made, based upon the students' words, as opposed to the need for speculation on my part had their original remarks remained unexplored.

Interview transcription

All writers on the subject emphasise the time-consuming nature of interviewing, both in relation to the interview itself and, in particular, to transcription of data, which in my study was carried out by myself. As was stated earlier, I used a tape-recorder, followed by verbatim transcription of material within 72 hours of the interview taking place, in order to minimise the risk of misrepresenting dialogue. In some instances in which students had made a particular response in a quiet tone, or in which there was external noise, the wording was muffled and repeated re-playing was necessary to ascertain what was said. On those occasions the proximity of transcription to taping was useful, as was the dual role of interviewer/transcriber, as my memory of what had been said was still relatively fresh. Guided by my theoretical and methodological notes (Schatzman and Strauss 1973:pp101-102), I noted within the transcript, in squared brackets, any pauses and instances of specific non-verbal communication such as head-shaking. My prior anxiety that tape-recording might inhibit responses was not borne out in practice.

Excerpts from transcripts presented within the thesis are unedited as, whilst editing provides a neater and easier read, it removes evidence of the students' efforts to locate the most appropriate words with which to express their exact meaning in a given situation.

Immediately subsequent to each interview I made notes, as it was frequently the case that students continued to talk for some time following cessation of taping. On each occasion that this happened I clarified with the student whether or not they consented to have these non-taped comments used as data and, in all but one instance, they were agreeable to this. On one occasion Anne requested that her comments were not used and, whilst I clearly did not make explicit use of what she said, the situation raised the question of the viability of honouring such promises. The inability to use the substantive issue which she raised did not have any serious implications for the study, but it is clearly impossible to expunge

acquired information from the mind and this would have the potential, not in this instance problematic, of affecting subsequent collection and analysis of data.

In addition to my notes on the comments made by students following cessation of taping, I also noted my impressions of the interview and the role of the student and of myself within it. These could be described as a combination of the theoretical and methodological notes described by Schatzman and Strauss (1973:ppl0l-l02), as I felt that strict demarcation between the two was impossible due to their mutual interaction and impact.

Data management

In recent years computer software has been increasingly utilised to facilitate qualitative studies, and as a number of researchers and writers commend this approach (Hammersley and Atkinson 1995, Miles and Huberman 1994, Richards and Richards 1995, Seidel and Kelle 1995), I explored it as a possibility. I obtained and used the demonstration disk for the QSR NUD.IST (Scolari, Sage, undated) package and discussed the advantages and disadvantages of this (and other software options) with two people who had used it in their own doctoral work. I was, however, unconvinced that its use would prove superior to a manual 'cut and paste' approach within my own study. The amount of data generated by thirty interviews, although large, was not unmanageable manually and I opted to use a computer only for the purposes of word processing and for the storage and retrieval of data. I felt, upon reflection, that the use of a 'cut and paste' approach would allow me to have a greater grip on, and direct vision of, the data and the categories which emerged. This decision is supported by comments made by Lofland and Lofland (1995), Coffey and Atkinson (1996) and Webb (1999).

The 'cut and paste' method of manual data analysis that I used enabled literal, as well as figurative, removal from the text of the chunks of data surrounding the coded fragments and meant that I could examine words or phrases within the text, both in isolation and in conjunction with preceding and succeeding sections. This process of deconstruction and reconstruction of data facilitated identification of their meaning both in isolation from, and in context with, other data.

Data collection and analysis

Use of a grounded theory approach demands that analysis and coding of data and its constant comparison with other data should commence immediately and proceed throughout the study. Schatzman and Strauss (1973:p108) describe data analysis as being a self-conscious, systematic and organised interaction between the researcher and the data and state that the fundamental operation is discovery of significant classes of things, persons and events and the properties which characterise them (p110). They describe the use of observational notes (p100), which should be self-standing as data and should contain the minimum of interpretation by the researcher. In my study, these comprised the interview transcripts.

Theoretical notes (Schatzman and Strauss 1973:p101) are described being self-conscious, controlled attempts to derive meaning from any one, or several, observational notes in which the researcher thinks carefully about the data and makes notes as to what appear to make conceptual sense. As stated earlier, I made these subsequent to each interview and again following transcription of the data. I also made notes on the comparison of data within single interviews, between different students during the same phase of interviewing and between the same student on the different occasions on which we met. This constant comparison of data was ongoing throughout the study and generated a large volume of written notes in relation to the identification of emergent issues and themes.

Schatzman and Strauss (1973:p102) also describe methodological notes, which are those made by the researcher following reflection and which take the form of a critique of his or her own tactics, identifying areas for future improvement. As stated earlier, I made these concommitantly with the theoretical notes, as the two are closely interlinked.

The approach to data analysis which I adopted for the first interview was that advocated by Strauss (1987) and Strauss and Corbin (1990), in which data are examined line by line and coded. I found this problematic, however, as a coding label which it seemed reasonable to apply to one specific sentence within the text of an interview could quite frequently be seen to be inaccurate when viewed in the context of the data in the rest of the paragraph, or within the interview as a whole.

As a result of this experience, the approach which I have subsequently adopted is closer to that advocated by Glaser and Strauss (1967) and Glaser (1978, 1992). I ensured that the collection, coding, comparison and analysis of data was a concomitant and ongoing process throughout the study. This enabled the use of the extant interview data to indicate areas for exploration during subsequent interviews and helped to ensure that analytical comments have been firmly grounded in the data.

Analysis of the data as described by Glaser (1992:p38-48) involves initial 'open' coding, during which data obtained are deconstructed to examine and compare them with other data in order to identify similarities and differences. The researcher at this point should ask her/himself of what category, or property of category, the incident is indicative, a category being described as a type of concept. Theoretical codes result from initial coding and constant comparative analysis of data. They relate to the conceptual (as opposed to the substantive) relationship posited between the categories and their properties as these emerge. As the study progresses, one category usually becomes identifiable as a core category due to its centrality, stability and easy relationship to the other categories.

Within my own study, data analysis led to identification of several hundred codes, each of which, following further analysis, was subsumed by one, or more, theoretical category. As detailed earlier, the core group of seven students were interviewed on four occasions. On *each* occasion analysis of the seven interviews yielded an average of eight conceptual categories, one of which was identified as being of central importance, in that all other categories bore a relationship to it and it was explanatory of most of the data.

The codes were frequently the students' own words, one example being the expression "*hands-on*". Although this did not always entail the physical contact that the phrase suggests, the term was used by students throughout the study to indicate intimate and direct involvement of nursing staff in client care. It was an activity that was invariably perceived as positive, both in terms of being the 'proper' remit of the nurse and of being a prerequisite for delivery of good care. In relation to the former, "*hands-on*" was one code which, in combination with many others, comprised the category, or theme, of *the nature of nursing work.*

"*Hands-on*" also had a strong association with other codes, for example, "*a person, not a patient*", that were subsumed by the category of *individualised care*. This example illustrates that a code might comprise one element of more than one theoretical category. When this occurred the code was placed within each category.

During the ongoing processes of coding, comparison and analysis of data, and subsequent to later analytical reflection, the purpose within a grounded theory approach is to attempt to discover what factor(s) account(s) for most of the variation in the way in which the participants process their concerns or problems (ie the core category, or the basic social process). One example of a basic social process is that of 'fitting in', identified by Melia (1981) in her study of the socialisation of student nurses. Another example is that provided by Artinian (1988) in her study of the relationships which nurses develop with cancer patients. 'Facilitating death' was identified as being the strategy (or basic social process) by means of which nurses resolved the conflicts engendered by dealing with dying patients.

Within my own study, one *major* category was identified from each of the four sets of interviews with the seven students. The categories are as follows:

- *finding their way* (following their second placement)
- *gaining experience and confidence* (half way through their programme)
- *partnerships in care* (at the beginning of year three)
- *prepared for practice* (subsequent to their final practice placement)

Upon completion of data collection, the data accumulated during the entirety of the study was once again examined and analysed. This revealed that, whilst the importance of *context* was explored in the greatest detail by the students within their final interview, it was *implicit*, in addition to becomingly increasingly *explicit*, within the students' interviews over the course of the study as a whole. Within the study *overall*, then, the *core* category (also the basic social process) that emerged as being of central importance to the students was that of *providing care in context*, ie demonstrating an awareness of, and sensitivity to, the specifics of an individual patient's circumstances, in order to determine the substantive care required.

Caveat

It should be noted that, within my study, categories did not emerge from the data as clear-cut entities, but inter-depended upon one another to a greater or lesser degree and an acknowledgement of this 'messiness' appears to me to be important. This concern is supported by Anderson's (1995:p126) suspicion of identifying what Strauss (1987:p35) terms "the main story here". Anderson emphasises the importance of nuances and sub-plots and points out that ambivalence and tension are appropriate reactions to complex social situations and worthy of presentation, rather than being viewed as a hindrance to the neat presentation of findings. There were, however, ultimately no *competing* 'main stories', as *providing care in context* over-arched all other categories.

The concept of saturation

Saturation of categories is said to occur when repeated collection of data from new sources fails to deliver anything novel in relation to that particular category and instead the same pattern is reinforced. Morse (1995b) emphasises that this does not involve a number count, but occurs rather by, "...investigator proclamation and by evaluating the adequacy and the comprehensiveness of the results" (p147). Glaser and Strauss (1967:p61) describe it as a sense of empirical confidence that the category is saturated and Mead (cited by Morse 1995:p147-148) is said to have described one index of saturation as being the boredom of having 'heard it all'. The foregoing necessitates researcher expertise, as does the notion of theoretical sensitivity (Glaser 1978, 1992), which refers to the utilisation of the researcher's knowledge, understanding and skill, in order to foster the generation of categories and properties and translate these into hypotheses in the light of emerging theoretical codes. The issue of researcher expertise is clearly relevant in my case, as this was the first occasion on which I had used a grounded theory approach.

Nonetheless, novice or otherwise, the concept of saturation is one which causes me disquiet. Mead's reported comment appears partially dependent upon one's boredom threshold and an adherence to it might result in premature closure on data collection. For example, during the interviews with the students in my study their accounts of nursery placements were universally negative, in that students

regarded such an allocation as pointless.[8]   Listening to students' grievances in relation to nursery placements pre-dated commencement of my PhD studies by three years and initially led me to a feeling of 'having heard it all'. I decided however that listening attentively and sympathetically whilst students unburdened themselves with fairly lengthy descriptions and explanations of the shortcomings of the placements was a reasonable quid pro quo for their preceding, or anticipated, discussion of experiences in which I would receive the information which I sought [ie which *I* deemed relevant]. It was only whilst re-reading the interview transcripts at a later date that I came to the realisation that the unifying factor underpinning their devaluation of the placement was that, on several counts, it failed to concur with their concept of *nursing* work. If I had, in this instance, relied upon a feeling of 'having heard it all', I might well have dismissed the students' accounts of nursery placements as being 'saturated' and achieved closure in relation to this aspect of their accounts. The fact that I listened, and subsequently re-examined the data, was serendipitous in shedding new light upon what the students in my study do, and do not, perceive to be nursing work.

The students' conception of nursing work will be examined in detail in Chapter Four. It is used here to illustrate the subjectivity of 'saturation' and the consequent potential danger of losing, minimising, or ignoring, valuable data. It also serves to highlight the role of the researcher in the research process, ie it is what the *researcher* deems to be of importance that is likely to drive the research agenda. However, having noted this, it is clear that availability of time within any research project is finite and closure requires to be achieved at some point, although identification of when this is appropriate may be arbitrary.

The longitudinal nature of the study

The data generated, the categories identified from these on each occasion on which the students were interviewed, and the core category (and basic social process) of *providing care in context* are clearly different to those which would have been obtained from a cross-sectional study, or from one in which a larger number of students were interviewed on one occasion only. For example, during

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[8]Although some students did add the rider that they had quite enjoyed spending time with at least some of the children.

the third interview, all students spoke, unprompted, about the beneficial effect of inter-occupational co-operation within the multi-disciplinary team. They identified the value of an inter-dependent approach to the delivery of health care and the benefits of sustained contact over time between patient/client and professional carer. Had all the data in the study been obtained at this point in the students' programme, the concept of *partnerships in care* would have been identified as the core theme, or category, in their determination of care quality. This data, however, although obtained whilst students were in university, was within several weeks of their having undertaken a community placement within their chosen branch of nursing. In the fourth interview, some nine to ten months later, the theme of partnerships was accorded no more than minimal attention. Reasons for this may be multi-factorial, the most obvious being that the placement most recently experienced is that accorded precedence within the students' accounts. It may also be that students assimilate the idea that partnerships in care are beneficial and thereafter experience no need to identify their importance explicitly. However, having said that, even when students were asked within the final interview to reflect upon, identify and discuss changes and constancies over time, the category of partnerships in care was not accorded precedence over others. The core category which did emerge by completion of the study was that of the importance of *providing care in context*. The students' perceptions of the positive effects of *partnerships in care* are overarched by the *core* category from the study overall, ie when such partnerships work effectively, they enable the care of the patient to be placed within a total context, rather than devolved and fragmented.

Similarly, some categories which appeared to be highly significant to students in the early stages of their programme, were accorded less discussion at a later date. This may be because the category itself, for example that of *institutionalisation*, has an initial novelty when first encountered, which fades over time as the student becomes socialised into the occupation and is replaced by other concerns. It did not appear that the effects of institutionalisation were any less evident in the students' later placements, but that they became, over time, a <u>sine qua non</u>. It is, then, the case that any claims for the significance of one individual category <u>vis à vis</u> another should be made with caution, as themes which appear of significance on one occasion may, on another, be ignored, or accorded only low-level status. Even if the category is drawn to the student's attention in a

subsequent interview, they may minimise its importance, or only recall it having been mentioned as a result of the reminder.[9]

As my study progressed I considered the possibility of giving the students their earlier interview transcripts in order to reflect upon these prior to subsequent interviews, but rejected this in case it focused their mind upon issues which were no longer uppermost in their mind. (The intention in returning transcripts to the students was not to obtain participant 'validation'. Morse (1998) emphasises that the researcher's purpose is to create an account of the participants' perspectives, using synthesis, conceptualisation and abstraction. As this is a product of *all* the participants' accounts, it will inevitably vary from the substantive account of any one individual and it is, then, inappropriate to use participant confirmation as an indication of the rigour, or validity, of a study.)

Whilst it is inevitable that the move from the substantive to the theoretical in data analysis requires seeking, extricating and labelling abstract principles which may underpin the data, making such links with any degree of confidence is problematic, as it entails mapping abstractions onto the students' accounts. It is, of course, to some extent inevitable that I do this, unless I adopt the stance of allowing the student voice to stand verbatim, without comment, a position which was earlier identified as unsatisfactory. It may also be argued that, even were I to adopt such a course, my own agenda for the research is pre-determined by my selection of research question, method, underpinning theoretical stance, and so on. However, as I would support those who contend that no-one comes to any situation without conceptual and empirical baggage, and that any notion of 'true objectivity' is wishful thinking or bad faith, it appeared to me that the best plan of action was to strive for impartiality in rendition of the students' accounts and to be as open as was possible to that which was contradictory of my own views and to seeming contradictions within the students' narratives.

In addition to the foregoing, there is a logistical problem which interferes with any neat categorisation of comments (even if I thought it desirable to attempt this), in that the students' narratives do not permit such labelling without concomitant decontextualisation of data, which then occludes their overall meaning and coherence. The students' thought processes, as vocalised, are considerably more

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[9]For example, Sheila and Jane in Interviews 25 and 27.

complex than such a method of categorisation allows. In contrast to the use of vignettes which, of necessity, have most supplementary detail removed and are thus truncated and sanitised as opposed to containing the 'messiness' of experience, the accounts generated by the students permitted deeper exploration of the means by which they processed their experiences. There is, further, a suspicion that neatly-packaged definitions may over-simplify the complexities contingent to everyday life and, thus, provide a misleadingly straightforward picture, from which data which does not 'conform' are allocated by the researcher to what s/he deems to be an approximate category.

Sample size and generalisability of findings

The fact that the sample size was small means that findings from the data are not, in any quantifiable sense, generalisable to the student body as a whole. However, as Morse (1999c) has pointed out, generalisability *is* a feature of qualitative research, although the criteria for its measurement differ from those in quantitative studies. In both, the aim of research is to develop and/or modify theory and subsequently transfer this acquired knowledge to a more general application beyond the immediate sample of people studied. In quantitative research there is the assumption that the findings from a group of randomly selected people with specific demographic features may be generalisable to a larger population who possess similar demographic attributes. In qualitative work the theory which is developed from the data obtained from a purposive sample should be applicable beyond the immediate group to others who are placed within similar situations.[10]

Whilst I am perhaps rather less sanguine than Morse (1999c) in asserting the generalisability of qualitative findings, at least in relation to my own study, I am equally less than convinced that quantitative findings are as 'generalisable' as is sometimes claimed. It would appear that, in any research enterprise involving human participants (including, of course, the researcher), some degree of caution and uncertainty re the findings, including their generalisability, comes with the

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[10]It might be said that, in quantitative studies, statistical generalisability is the aim, whereas in qualitative studies, the aim is generalisability of theory that has been developed.

territory. This being the case, acknowledgement of these limitations seems the more constructive, and possibly less misleading, course to pursue.

Summary: methodological issues and procedures

Within this chapter it was identified that the area under investigation, ie student nurses' perceptions of the patient/client care which they encounter during their practice placement allocations, is one about which there is little published research. It thus appeared that a qualitative, grounded theory approach to the study was appropriate, the underpinning theoretical perspective of which is symbolic interactionism.

Informal, relatively-unstructured interviews, designed to allow careful exploration of participants' perceptions and concepts, were carried out with ten volunteers who were undertaking the Diploma of Higher Education in Nursing programme. Three of the participants were interviewed on one occasion, whilst the other seven were interviewed on four occasions[11], comprising a total of thirty interviews.

Data analysis commenced at the outset of the study and continued as an ongoing process throughout. This was carried out manually, using a 'cut and paste' approach. Text was deconstructed in order to carry out initial, open coding and, subsequently, theoretical coding and category formation. The category which emerged as being the core category, so-called because of its centrality, stability and ability to account for most of the data, was that of the importance, in the students' perspective, of *providing care in context*. Factors which may facilitate, or inhibit, the delivery of 'care in context' will be identified and discussed within Chapter Four which reports upon the study's findings.

As some of the facilitative and inhibitory factors were attributed to structural and some to individual attributes, the work of some of the theorists who explore these (Mead 1934, 1964, Blumer 1969, Goffman 1974, Giddens 1984) has been outlined and discussed, in order to assess their potential explanatory relevance in relation to

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[11]With one exception: one student in the core group was interviewed on three occasions, as he had an assessment resubmission at the time of the second interviews.

this study. It was argued that, whilst it may not be possible, or desirable, to rely upon the ability of any one theoretical perspective to explain the complexities of human cognition, affect and behaviour, an interactionist approach, despite its critics, is sufficiently flexible to provide the theoretical basis for my own study.

Following an explication of the suitability of a grounded theory approach, based upon an interactionist perspective, the advantages and disadvantages of the methods of data collection (informal, relatively-unstructured interviews with students) and analysis (concomitant collection, coding and comparison of data) selected for use within the study were identified and discussed and the rationale for their use provided.

Chapter Four

Presentation and Discussion of Findings

Introduction

Prior to exploration of the students' perceptions of the patient/client care that they encountered during their practice placement allocations, it seemed important to identify the concepts underpinning *their* views on care as related to nursing. The first section of this chapter will, then, discuss the data which pertain to this. Within Section One of the literature review, theoretical work and empirical studies relating to the concept of care were discussed and summarised and further comment will be made within this chapter on the relationship between these and the findings from my own study.

Following an examination of the students' conceptualisation of *nursing* care, Section Two of this chapter presents and discusses the students' perceptions of care quality and the criteria used by them in their deliberations. This reflects the structure of the second section of the literature review, in which literature on moral reasoning and moral judgement was summarised and discussed.

As stated earlier, I adopted a grounded theory approach to my study, the underpinning theoretical stance of which is symbolic interactionism. The extent to which this is explanatory of the data within my study will be discussed, as will the potential relevance of frame analysis and structuration theory, both of which were outlined within Chapter Three. In exploration of the students' accounts, it was necessary to look beyond the 'micro' situation (with which symbolic interaction is most closely associated) and examine the structural issues which impact upon care delivery and the student experience.

Whilst the study's findings are presented within this chapter under category headings in order to facilitate analytic comment, these categories are, in reality, not discrete, freestanding entities but, rather, interconnect, overlap and co-depend. The data only acquire overall coherence when the sum of the component sections is aggregated and the later sections of this chapter, and Chapter Five, will attempt such a synthesis.

Thus, the overall aim of this chaper is to describe, explore, analyse and discuss the students' perceptions of the care that they encountered, and in which they participated. One area of interest relates to the processes used by the students in their determination of care quality, specifically the changes and constancies in processes over time, and the possible explanations for these. The other area of interest, closely linked to the first, is that of the categories, or themes, which emerged from the students' accounts during their discussions. These underpinned their perceptions of, and reactions to, the situations that they encountered. As was discussed in Chapter Three, it was the case that, whilst some categories remained identifiable over time, others were less constant, in that they might be accorded precedence in one interview, but scarcely mentioned in another. The category which emerged, over time, as being the core category, and which was also the basic social process, was that of *providing care in context*. The rationale for identification of this as the core category (ie, its stability, centrality, relationship to all other categories and its ability to account for most of the data), will be explicated.

As noted in Chapter Three, and in the Appendix, students undertook placements in a variety of settings. The noun used as a descriptor of the individual for whom cared was provided thus varies. Within hospitals, for adults whose problems are designated as physical, the term is usually 'patient', whereas in areas caring for individuals who have mental health, or learning disability, problems the term 'client' is preferred, as it is for those in community settings. In areas providing residential continuing care, the term is usually 'resident', although sometimes 'patient'. Thus, within this chapter, the noun used to describe those for whom care is provided will follow the above pattern. When authorial comment of a general nature is provided, the term used will be client.

Section One:
The nature of nursing work

Introduction

Although the concept of care has been longstanding, if frequently implicit, within nursing literature, it appears only within the past twenty years to have been addressed in depth within the arena of social science. A large volume of the early

work within the latter has as its focus the unpaid caring work which is carried out mainly by women in the domestic sphere, some of the initial stimulus for this being the increasing policy emphasis on provision of care within the community, as opposed to within health care institutions. Much of the early literature, for example Finch and Groves (1980), explicates the concern that the onus for care delivery would devolve to women, despite the fact that, in official documentation, discussion of community care provision was couched in gender-neutral terms. The theoretical concept of care was also an area explored by those within the field of applied social science, one much-cited and and influential contribution being that of Graham (1983). Graham's discussion, and that of others from within the same field (for example Ungerson 1983), focuses on the concept of caring as being unpaid work carried out by women in domestic settings and this early work was significant in challenging, and attracting the attention of, social policy makers. It has however been the subject of subsequent criticism, for a variety of reasons. It focuses upon the potentially burdensome aspects of caring, as opposed to its rewarding aspects, and upon women as carers, to the virtual exclusion of men. It fails to acknowledge that children may act as carers to parents or siblings and that people of different ethnic origins and different socio-economic classes may have very different attitudes and experiences. It also focuses in its entirety upon the carer and not the person being cared for, with the result that the latter is perceived as passive and the former as agentic. Additionally, and importantly for health care workers, and for my own study, the emphasis within this body of literature is upon unpaid care within a domestic setting, which differs from the focus provided by writers in relation to remunerated caregiving provided for patients and clients in nursing work.

Davies (1995a) differentiates between 'caregiving work', which refers to caring carried out on an unpaid basis within networks of family and friends and thus to the work cited within the previous paragraph, 'carework', used by Davies to refer to a variety of paid jobs within the health and social services (for example home helps) and 'professional care', which refers to caring work carried out within the public sphere and for which the carers have received a systematic and formal preparation for practice (pp20-21). Whilst it is clearly the latter which is of substantive relevance to this study, the impact which the idea of care provision as something which originates in the domestic sphere and which has been, and continues to be, carried out for the most part by women, is clearly of significance in relation to the status of those who carry out work seen to derive from a similar

root, albeit in a different (and paid) setting. It is important therefore to acknowledge the work which has provided exploration and analysis of 'caregiving work', in order better to identify the standing, and potential contingent problems, of 'professional care'.

'Just not nursing'

In relation to the concept of saturation, I identified within Chapter Three that re-reading of interview transcripts subsequent to the students' nursery placements provided me with an understanding that their negative comments about the experience were because they did not view the care of healthy children as being of relevance in preparation for practice as a nurse. Clearly, the children in these settings required 'care', but not that which was accorded value by the students in relation to *nursing* work. It seemed, rather, as though the perennial nature of caring for healthy children, carried out in 'everyday' life by people, for the most part women, with little or no preparation for practice, was responsible for its devaluation. It is of interest that caring for people who have learning difficulties was not similarly devalued by the students, although in many cultures this type of care is not viewed by society, either officially or informally, as comprising 'nursing' work. That students *did* accord value to this latter experience, and clearly viewed it as 'nursing', may be due to the fact that, within the UK, caring for people who have learning difficulties has been, and remains to a lesser extent, perceived as an activity that requires skills deemed to be 'nursing'. It may also be that the students identified people who have learning difficulties, and the care which they subsequently require, as being apart from everyday experience, in a way in which 'healthy' children are not.

Practice placements that the students identified as a relevant preparation for nursing practice appeared to necessitate, then, caring for people who have a clearly identifiable (although not necessarily visible, viz. those who have a mental health problem) need for attention that lies beyond that which could be delivered by a lay person.[1]

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[1]Indeed, as will be discussed later, the greater the distance from the type of care perceived as being achievable by a competent lay person, the greater the concomitant status and perceived glamour, viz. emergency room and intensive care nursing.

Whilst to members of the lay public the foregoing may appear to be a sine qua non, due to the unquestioned assumption by media representations that nursing work entails care of 'the sick', the finding is of significance in its contradiction of the emphasis placed in recent years, by policy-makers, upon the role of the nurse in relation to *health* care. As outlined in Appendix One, the emphasis in nurse education until the 1980s upon care of ill people within institutional settings was one stimulus for the radical revision of these programmes.[2] It was proposed at that time that there be a move to an educational preparation for practice which focuses upon care provision within both institutional and community settings and also upon health promotion and health education.

The focus during the Foundation Studies curriculum is therefore upon health, rather than illness. The students who participated in my study clearly did not view nursing work in this light. Their reason for becoming nurses was to care for people who have some form of health care deficit and, whilst health education and health promotion have their place within their conception of nursing work, it is most certainly not its raison d'être.[3]

One example which illustrates the foregoing was provided by George, immediately prior to completion of his three year course, in discussion of caring for people recovering in hospital following myocardial infarction.

> George:
> ...I think health education, I think is helpful to good care. You know, we have to be health educators as nurses and health promoting em [pause] it's like we try to keep our patients out of hospital as much as we can, although

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[2]A succinct and lucid outline of the background to the *Project 2000* proposals is provided by Davies (1995b:ppl08-ll2), who was project officer at the UKCC and author of the discussion papers and final report (United Kingdom Central Council 1987).

[3]It should be said that the views expressed by the students within this study support criticisms of a similar nature provided by many of the students who have undertaken the 1992 Diploma Programme. Student disquiet in relation to the health, as opposed to ill-health, focus of the Foundation Studies' component has been made known, both formally (ie in written evaluations and representations to the Student/Staff Committee) and informally, in the form of personal communications by students to lecturers.

it'll maybe take, take away our job [smiled], but I think there will always be people that are ill...

Dorothy:
So you would see that as quite an important part of good nursing care as well? Trying to prevent the patient coming back another time?

George:
Yeh, trying to, to work out the reason *why* they've actually been in this time...
(Interview 28:pp 10-11)

The foregoing illustrates that, from George's perspective, the nurse's role in health education and promotion takes place once the patient has been ill, in order to prevent recurrence, rather than as a pre-emptive strike. Indeed, if ill-health *could* be prevented for all the population, it would remove the nurse's role, not enable, facilitate, or fulfil it.

Therapeutic intervention versus containment

Further to the requirement that nursing work involves care of those who have a health care deficit, the care which is provided must demonstrate a clear and direct therapeutic intent. Whilst this may appear tautological, the care which students witnessed did not always, in their perceptions, entail such a correlation, a point identifed, for example by Jim, speaking of his experience within forensic psychiatry, an area in which he viewed the 'care' as custodial, rather than therapeutic.

Jim:
...There was very little [pause] deliberate building of therapeutic relationships, I found. But that's me being judgemental, I, I, you know, I just think it was very custodial. A lot about control. [pause]

Dorothy:
Hmm. What would you say *does* make a good therapeutic relationship. From what you're saying you didn't [Jim started talking]

Jim:
I, I think it's em [pause], equality. I'm not sure equality's the right way [ie to express it], but it's certainly a two-way flow of information. And, taking into consideration the needs, the genuine needs and wants of someone. And not just control all the time...I think the idea of a therapeutic relationship is an equal relationship. I don't think that, in a situation like that, you have any

sense of equality at all...because of the environment [ie secure unit], you tend to forget it's a hospital you're in. It's not a prison. But it does certainly have that warders' type of thing, which I just didn't like at all...I'd also even go so far as to say that...some of these people aren't nurses that work there.[4] I don't know what, how they would describe themselves, or how they would justify what they do, but I wouldn't describe them as nurses, in, in my understanding of nursing...

Dorothy:
Mmm. So, what would your understanding of nursing be, then?

Jim:
My understanding of nursing? [laughed] Is being caring and to help eh, unconditional positive regard [both laughed: Jim's tone was mocking, as he was producing a 'textbook' definition][5] And [serious tone resumed] eh, to eh, be a caring sort of person. To be understanding, to be open-minded. [pause] And not to be a bully...
It's [forensic psychiatry] not an area of nursing I'd like to, to work in. You know. It's, it's a bit too close to the prison service for my liking
(Interview 2l:pp 2-5)

In the foregoing extract, the problem appears to be that the care provision was aimed at protection of the public (and staff), as opposed to being implemented for the benefit of the patient. The emphasis upon custodial requirements, the consequent restriction of patients' freedom and the potential for imposition of sanctions by staff in the face of 'undesirable' behaviour, precluded the possibility of equality in status between nursing staff and patients. This, then, in the absence of attempts at therapeutic intervention by the majority of staff, entailed that Jim did not view it as constituting 'nursing' work.

Similar comments were made by Alan, following his placement experience within the state hospital. He contrasted the atmosphere within the ward areas, which he described as prison-orientated, and in which the focus was upon containment, with that of the various therapy units (for example arts and crafts, education, sport),

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[4]Jim did not mean this in a literal sense ie the workers within the unit *were* registered nurses: he meant, rather, that their role was not that which accorded with his own understanding of nursing work.
[5]It was frequently the case that, when asked to define a concept about which they had received theoretical input within the university, the students provided a mocking rendition of textbook terminology, prior to their 'own' rendition (which, of course, is likely to have been influenced by the former).

which the clients attended during the day and which he viewed as being therapeutic (Interview 26:pp 2-3).

Nursing versus social care

For some of the students, the role of the nurse in relation to client care was at times unclear. This tended to occur in areas in which the demarcation between the roles of different healthcare occupational groups was not made explicit. Whilst a partnership approach between the different occupational groups in the provision of health care was one which was, in general, viewed favourably by the students in my study, erosion of nursing work by others, or by the demands of the organisation, was viewed as problematic, as was adoption of what were perceived as social care, rather than nursing care, interventions. In the following extract, Euan described his placement experience, early in his Mental Health Branch programme, in which he accompanied the community psychiatric nurse (CPN) for several weeks.

> Euan:
> ...Care of the elderly, CPN placement. Hmmm. [pause] I felt there was a lot of overlap, a lot of the stuff that needed to be done was social workers, rather than, [it was] just checking that they're [clients] ok, that they've got their benefits, you know? Um [pause] As far as the actual nursing was concerned, I didn't feel there was a lot of nursing involved. [pause] Apart from the likes of medication.

> Dorothy:
> Right. So the care that was given was mainly in the line of medication and things like benefits?

> Euan:
> Yeh. I felt it was one of the classic situations where patients were, you know, nurses and social workers were at each other's throats. Yeh.

Euan went on to say that he felt that a lot of elderly people who have mental health problems are isolated at home and that he thought that more should be done to alleviate this. He then spoke about the role of other health care workers, as follows:

Euan:

...I think the other thing I felt was, I was just gob-smacked by how much home helps do for some of the clients. I mean, these people do *far* more than they're paid to do...

And, in a way they do what nursing assistants do in wards, em, you know and eh, maybe just felt that we should have been doing more of that sort of stuff as well.

Dorothy:

Hmm. So you felt that some of the care that was being done by the home helps was what should really be *nursing* care. What sort of things?

Euan:

Hmm. Bathing, you know. Em [pause], hmm, nothing particular. But just the sort of, the whole social aspect, you know?...I felt we should have been [pause], maybe we need to do more, you know, and look at what being a nurse in that setting actually means. [pause]

Dorothy:

...And how did the CPNs see their role then, because it sounds as if?

Euan:

I'm not sure. I'm not sure that they had a particularly clear idea of, you know [pause]. I'm not sure about that. But I didn't particularly enjoy it, for that...

Dorothy:

Yeh. What was it you didn't enjoy then, particularly?

Euan:

[pause] I, I felt under-used. Em, I felt because they weren't clear about what was wanted from them, em, it rubbed off on me...

(Interview 20:pp 1-3)

In the foregoing, the problem for Euan appeared to emanate from what he perceived as being the CPN's own lack of clarity about the parameters of her/his job description and the fact that the care encounters which he experienced whilst undertaking this placement did not concur with his own ideas of the CPN's role. Interventions by the CPN which were viewed as comprising social care, as opposed to having a direct relationship to the clients' mental health problems, were not viewed positively.

Preparation for practice, as a remunerated practitioner…

Three other aspects of the students' perceptions of the nature of nursing work were inter-related and will, for that reason, be discussed concomitantly. In order to be considered as 'proper' nursing, the care provided required to be given by someone who had received a formal preparation for practice, had a public/occupational role in relation to the person being cared for (as opposed to a private/domestic relationship), and received financial remuneration in recognition of this.

…but more than 'just a job'

In relation to financial remuneration, however, it should be noted that students regarded nursing as 'more than just a job', as was for example noted by Alan in relation to his allocation to the state hospital. He acknowledged that he would have been able to secure a registered nurse post on completion of his programme, and that the terms and conditions that accompanied it would have been good (Interview 26:pp ll-l2), but he considered that the atmosphere, which for the most part was aimed at containment as opposed to rehabilitation, was not what he wanted as a nurse. He had earlier made critical comment about many of the staff, in the following terms:

> Alan:
> …I think a lot [of staff members] as well, they're motivated by money, it's not the job [ie the content], you know, it's just a way of earning money. That's, I mean, they've lived there, they've worked there twenty-five, thirty year[s] and there's not many job opportunities round [there] at all, you know…
> (Interview 26:p 2)

So, then, although remuneration was valued for its role in acknowledgement of the formal and specialised nature of the nurse/client relationship, it was not, in itself, all-important (although this comment does not, of course, negate the pragmatic necessity to obtain financial recompense for provision of labour).

Preparation for practice in the public domain

The discussions with Anne provided a good example of the requirement for nurses to have an officially-acknowledged preparation for practice and a formal, as

opposed to domestic, relationship with the person being cared for (which would, then, involve remuneration). In my first interview with students, I asked them if they had gained any experience in health care work prior to commencing the diploma course. The interchange with Anne was as follows:

Dorothy:
...Usually I start off by asking if anybody's had experience before of health care work, before you started the course?

Anne:
No, not um [pause] not in an actual hospital setting, although I did look after my grandmother for a wee while.

[pause]

Dorothy:
But that would give you quite a bit of insight into what's required?

Anne:
Yes, she was into her 90s and [pause] dementia. She'd had diabetes for most of her life, um. She became bedridden for the last couple of years - and confused. And it was just sort of basic care. Sort of, I mean she was still awfully independent and tried to go to the toilet by herself and you ended up half carrying her, um, but I think that was what she held on to at the end, you know? The last wee bit of dignity. I was, you know, helping her to eat and talking to her really and chatting. Chatting about, sort of, old times. She could remember back 80 years, to the turn of the century, but she couldn't remember what I said five minutes ago.
(Interview 9:pp 1-2)

In the foregoing, it was of interest that, although my initial question did not specify the location of care experience, Anne's answer assumed an identification of 'proper' health care with an institutional setting. Also of interest was her designation of the care which she provided for her grandmother as, "...just sort of basic care", although it was clear from her description that her grandmother required assistance with most of the activities of daily living. In a later interview, subsequent to her care of the elderly placement (Interview 22:pp 1-2), Anne's description of her activities indicated marked similarities to the care that she had provided for her grandmother. In the later interview however, it was evident that she regarded her care of the elderly placement experience as 'nursing', in a way that the care for a family member was not and it is arguable that the difference in her view derived from the formal preparation for practice which she had by then

received, the setting within which care was provided and the formal/public relationship, including financial remuneration, accorded by her status as a student nurse.

The hierarchical nature of health care provision

The effects exerted by the organisational framework within which health care is delivered are the subject of a separate section of this chapter, but it is necessary at this juncture to comment upon the students' views, as these provided insight into their conception of nursing work. Nursing as an occupation was perceived by the students as being hierarchical, which they regarded as negative, for the following reasons. Nursing should, in the students' view, be 'hands-on', the use of inverted commas indicating the term's common usage by students (although it did not in every instance signify the actual physical contact that the wording might imply: it signified, rather, the direct involvement of the individual nurse in the implementation of care). The problems attendant upon upward mobility within the nursing hierarchy were that it almost inevitably necessitated a movement away from direct client contact as a result of the concomitant acceptance of responsibilities which the students in my study deemed to be peripheral, if not external, to the core of nursing work. The completion of large amounts of paperwork was one such requirement, budget responsibility and accountability was another. The irony that those most qualified to undertake nursing work are those who are the least likely to be involved in its direct delivery was not lost upon the students, nor was the fact that those then left to provide nursing care are those who are the least formally qualified to do so.[6]

George provided a discussion of several of the foregoing points in the interview which followed his final practice placement prior to award of the diploma. He viewed the erosion of nursing work by clinical support workers as problematic, although, interestingly, the example he cited was that of phlebotomy which, until recently, would not have been perceived, outwith specialised settings, as nursing work. George considered that the diploma programme enabled him to apply theoretical principles to practice situations, as opposed to training him in the implementation of specific procedures. He regarded this as desirable, both in

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[6]This irony has been identified and explored by several writers, for example Melia (1981, 1987) and Davies (1995b:pp90-105 et passim).

relation to the the quality of patient care he was able to provide and in relation to his own job satisfaction (Interview 28:p 6).

The importance of 'hands-on' care as integral to nursing work was identified by George in our first discussion (Interview l0:pp 3-4), as was the shift away from it by the majority of qualified staff. The discussion during the second interview was as follows:

> George:
> ...I think, em, staff nurses on the other hand [ie as opposed to unqualified staff], tend to want to be seen to do *qualified* nurse, nurse things, you know? [Dorothy: Yes] Like, doing a dressing. Like, doing the drugs. Em [pause] checking IV sets and [pause] blood, and controlled drugs and things like that. It's better to be seen doing those things.
>
> [pause]
>
> Dorothy:
> Mhmm. And do you think, yourself, it's better to be seen doing those things, or?
>
> George:
> No. Coz [pause] it's [pause] I think [pause] I don't, I'm not, I don't think it is better to be seen doing those things...it's 24 hour care and things like counting the controlled drugs should be done at the start of a shift and you don't have to do it again... all these things can be done another time that I think a lot of staff nurses rush off to do, rather than spending time with patients. It would be much better if they spent time with the patients...staff nurses...forget to do simple jobs, that would mean so much more for a patient. Em [pause] like, if a, if a patient asks a staff nurse to put, say put them on the toilet. Then the staff nurse'll maybe [pause] come to the student or the auxiliary and ask them to do it because they've [staff nurse] got to go and check somebody's IV pump or something...they'll go off and do that while the staff below them do the menial task of putting the patient on the toilet. Which is quite a personal thing, for the patient who's being put on the toilet...If they can identify with a nurse like, like their primary nurse, who is nice and kind and, and thoughtful and spends time with them and go[es] through a personal experience like being put on the toilet by somebody...I think that helps in the bond...
> (Interview 23:pp ll-l2)

In the foregoing, the importance of the direct delivery of patient care by qualified staff is made clear. Whilst administrative and technical work has its place in the

scheme of things, it should not, in George's view, be allowed to supplant the main focus of nursing work, which is direct patient contact and interaction. Several other points of interest arise from George's account, for example, his designation of providing assistance to patients with fundamental activities of living as both 'simple' and 'menial'. This type of care was viewed, in his account, as being devalued by qualified staff, who preferred to involve themselves in activities specific to registered nurses, which they perceived as being of higher status. Tasks which could be carried out by unqualified staff (and which can, and frequently are, carried out by informal carers in domestic settings) were delegated to others. Although in his account George used the word 'menial' when talking of assisting patients to go to the toilet, it was clear that he regarded this, and similar activities, as being of importance in the process of trust-building and bonding between patients and staff and therefore a fundamental aspect of nursing work.

The devaluation of aspects of nursing work which are 'low tech.', or which involve care of client groups who are not highly valued within our society, will be discussed later, but it is of interest (a point identified earlier) that the areas which are accorded the highest status are those which provide the clearest evidence of a demarcation between care given by 'experts' and that which can be provided by a competent lay-person.

As frequently occurred in the students' narratives, contrast was used in this instance by George in order to emphasise his point. He followed the above description with a detailed account of a charge nurse in his subsequent ward of allocation, who regularly involved herself in direct patient care, to the consequent benefit of patients and staff, who benefited from her theoretical and clinical expertise.

The hierarchical structure of nursing was also denigrated by Jim, who commented that it had an adverse effect upon patient care and nursing staff. When I asked him whether he felt that the rigid demarcation of occupational roles was imposed by the organisational structures, or was adopted willingly by some individuals, Jim said that he felt that there was an interplay between these factors. He indicated that, had those in charge wished to change, then greater efforts would have been made to listen to the contributions made by those at a lower level within the hierarchy (Interview 30:p 1). This is a point to which I shall return later, in discussion of the interplay between structure and action.

Jim identified nursing knowledge as being accorded less value (by clients and staff) than medical knowledge, the former being viewed as being more everyday and anecdotal in nature than the latter, which is viewed as 'scientific' and authoritative. Nurses, in Jim's view, were perceived by patients and clients as being approachable, particularly when assistance of a practical nature was required, whereas information in relation to diagnosis, treatment and prognosis was seen as the prerogative of medical staff. Jim linked this with the different ways in which nursing and medical work are organised, the former providing a more sustained contact between the practitioner and client than is possible within medical practice. The intermittent, often fleeting, encounters between medical staff and clients are frequently accompanied by a degree of ceremony, which Jim identifed as contributing to medical mystique. Jim's selected branch of nursing was Mental Health and the issue of the power which psychiatrists may wield over psychiatric patients was identifed by him. It will, additionally, be the subject of further comment at a later point within this chapter. He felt that the nature of some of the clients' problems entailed a desire for the certainty which could be provided by a rather distant, authoritative figure. He also considered that the lack of public awareness of the preparation for practice which nurses receive, and in some instances the latter's lack of assertiveness, is in part responsible for the differing status of the occupations (Interview 30:pp 5-7).

It may be seen from the foregoing that the students, in their efforts to clarify their meaning, quite frequently used contrast. In relation to the concept of care as it related to nursing, this entailed that, in their descriptions, they frequently identifed what was *not*, in their view, nursing work. This exclusion of certain activities, behaviours or attitudes facilitated conceptualisation of what *was*, to them, the remit of the nurse.

'Hands-on' versus 'admin.'

At the time of our final interview session, George continued to express the view that qualified nurses should be visible to patients and use their acquired expertise in care delivery and in provision of teaching and supervision for more junior staff. In the ward to which he had been allocated, the charge nurse spent most of the time co-ordinating care and carrying out administrative work, including dealing with the budget for care delivery.

George:
...I, I just felt that, em, there's, there's a time and place for paperwork...if I had twenty years' service I'd want to be able to say to people, "I've been doing this for twenty years and this is *my* experience I'm going to give to you. I'm going to share this with the patient because I feel it's valuable", rather than, I don't know, working out a budget plan...obviously they have to be done, but, em, I just thought there was a time and place and it shouldn't, I don't feel it should be done by G grade sisters at 7 o'clock in the morning. [pause] But, I think that, that there's this, I suppose *traditional* aspect of [pause] 'the navy blue uniform is the sister, or, or, the matron' and I mean patients look up to that I think and if they see somebody who's just there every now and then, just popping their head in, then I think that they, I don't know. I think that patients don't look for people like that? They look for the name, 'sister', they look for the name 'nurse', 'doctor' [pause] and so, like a traditional thing. And if the person who is the sister is just popping in every now and again, then I think that they, they lose some of the patients' respect. As opposed to being a valued member of the team by all. [pause]

Dorothy:
So, for you, nursing work then would be very much [pause] hands-on nursing work and not simply the background paperwork?

George:
Yeh. I think that, I think that nursing is a hands-on job. Em [pause] I think that it's something that you have to be able to [pause] communicate and, em [pause] I, I just feel that it, it should be done, carried out by people, dealing with people, working with people, as opposed to [pause] taking that role away...as nursing moves on and on and on, gradually the nurse is being removed from the, the bedside work, which I think is why quite a lot of people come into nursing, coz they enjoy that one-to-one, or one-to-four interaction with, with people...
(Interview 28:pp 4-5)

In the above extract, George expanded further upon his ideas of the fundamental importance of the nurse's direct delivery of care in his definition of nursing work. On this occasion, he placed an additional emphasis on the patients' (and, by extrapolation, the public's) perception of a charge nurse as being someone who has a high visibility rating and whose command of public respect is, at least partially, dependent upon fulfilment of society's expectations of behaviour. What is also of interest was George's association of a nurse with a uniform and with the title of sister or matron as, although he stated that he was describing the

expectations of patients, he did not attempt to distance himself from such images of nursing.

George's account is used because it encapsulated similar themes identified and discussed by other students, particularly in relation to the 'hands-on' elements of nursing work. Students provided detailed and emphatic expression of the view that administration, if regarded as nursing work at all, should be clearly subordinated to direct patient contact. All students, in their first interviews, conveyed surprise at the amount of what was collectively referred to as 'paperwork', that the qualified staff were required to complete. Initially, they appeared, however, to accept this as constituting a <u>bona fide</u> reason for the staff's frequent inability to implement direct patient care. By the later interviews, however, 'paperwork', in its various manifestations, was viewed negatively and indeed with cynicism. The marked reduction in its acceptance by students was due in part to their feeling that, in at least some instances, the requirement to complete paperwork was used by qualified staff as an excuse for non-participation in care which they viewed as low status.

Another reason for the denigration of 'paperwork' by students was their perception that its volume did not appear to have any positive correlation with the quality of patient care provision. In some placements students' perceived paperwork as becoming an end in itself, as opposed to a means by which care provision might be enhanced. The latter purpose was, in the students' view, its sole justification.

Summary: the nature of nursing work

In summary, it may be said that, for the students, designation of care as 'nursing' work entailed fulfilment of the following criteria:

- the individual being cared for required to have some form of health care deficit (ie this precluded care of healthy children in a nursery)
- the care provided required to relate directly to the health care deficit (and could not, for example, be custodial, as opposed to therapeutic)
- the care provider required to have a formal preparation for practice, a public/occupational role in relation to the person being cared for and concomitant financial remuneration in recognition of this.

In addition to the above, the hierarchical nature of nursing was not viewed positively, as promotion usually entailed movement away from direct contact with clients. Following promotion, in the students' view, a client focus was supplanted by reponsibility for administrative issues and this was not perceived by the students in my study as the proper remit of the nurse.

The foregoing key concepts, held by the students in relation to nursing work, provide the foundation upon which their descriptions of care will be discussed and analysed.

Section Two:
The students' descriptions of care

Introduction

Students frequently used contrast, in order to highlight the difference(s) between care which they perceived to be of a good, or of an unsatisfactory, standard. For example, when I asked Mark to describe an incident in which things went badly, or well, in relation to care delivery, he described being in the ECT[7] department when a staff nurse arrived, accompanying a client. The nurse had talked Mark and the client through the procedure and had emphasised to Mark how important it was, "...that the last thing the client heard before the anaesthetic was the nurse talking to them and reassuring them and the first thing that they heard when they came round was the same nurse speaking to them". This had remained in Mark's mind as a positive experience, both in relation to the nurse's willingness to speak with him and in the observation of the nurse/client interaction. This encounter was immediately followed by the arrival of another client, who was, "...with an auxiliary who just didn't say anything really. So, if I ever escorted anybody to ECT, I would try to do what the first nurse did." (Interview 3:p 8)

One issue which emerges from Mark's description is that sustained contact between nurse and client may facilitate the delivery of contextual care. Another is

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[7]Electro-Convulsive Therapy

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the difference between the approaches of qualified and unqualified staff.[8] These
issues will be discussed later in this chapter, but the purpose of their citation here
is to provide one example of the use of contrast by a student in order to emphasise
their point.

It should be noted, at this point, that the students seldom used abstract principles,
for example those of beneficence or autonomy, to label their values, or their
thought processes. This may have been in part because I did not request this,
although it is of interest that the opportunity was there for them to do so, but in
the main was either ignored or disregarded.[9]

Category Identification

As detailed in Chapter Three, constant comparison of data was ongoing
throughout the study and resulted in identification of several hundred substantive
codes which were subsumed by twenty-seven theoretical categories. Analysis of
data during, and immediately subsequent to, the four occasions on which students
were interviewed generated the following *major* categories:

- *finding their way* (following their second placement)
- *gaining experience and confidence* (half way through their programme)
- *partnerships in care* (beginning of year three)
- *prepared for practice* (subsequent to their final practice placement)

Subsequent to the students' final interview, the data and accompanying
methodological and theoretical notes compiled during the entirety of the study
were again analysed. This revealed that *providing care in context* was *the* theme
which underpinned the data within the study as a whole. Whilst the importance of
context was discussed in the greatest detail by students within the fourth interview,
it was *implicit*, in addition to becoming *increasingly explicit* over time, within the
earlier interviews. Students' accounts of good quality care were those in which
care was *contextualised*, ie tailored, not only to the client's physical or mental
health problem, but to the psychosocial context within which the individual was

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[8]This was not always, in the students' accounts, to the detriment of the latter.
[9]Students had received theoretical input in relation to these concepts.

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situated. Care of poor quality, by contrast, was that which failed to acknowledge, or actively ignored, the client's context. Thus, whilst one major category was identified from each set of interviews (and would have comprised the 'core' category had the interviews been carried out on that occasion only), the longitudinal nature of the study revealed one *overarching* category, to which *all* other categories related. This core category, and basic social process by means of which students deemed care provision to be satisfactory or otherwise, was that of *providing care in context*. The major categories from interviews one and two (*finding their way* and *gaining experience and confidence*) constituted the foundation upon which students were able to access what some termed 'the wider picture' (ie the total context). The major categories from the third and fourth interviews, (*partnerships in care* and *prepared for practice*), were overarched by the concept of *providing care in context*. For example, the reason why *partnerships in care* were valued by the students was because they helped to place the client's care *in context*. Being *prepared for practice* entailed acknowledgement that *providing care in context* was a prerequisite for delivery of high quality care.

Providing Care 'in Context'

As stated above, the core category and basic social process which emerged over time was that of *providing care in context*. The students accorded increasing importance to this within their accounts, in their designation of the quality of care provision as being satisfactory, or otherwise. The emphasis which students placed upon context in their later accounts was viewed by them as resultant from increased experience of caring for clients in different situations and in listening to the perspectives of others. These 'others' included clients and their visitors and carers, the student's relatives and friends and other health care providers.

The concept of context, in the students' accounts, comprised a number of different inter-connecting and inter-dependent components, including the care setting and the individual client's problems and needs (recognition of which required background as well as current knowledge of the client, including awareness of, and sensitivity to, social factors). Care providers required relevant theoretical knowledge and practical experience in order to contextualise care. These points are of importance, as the students considered that the knowledge and experience

required to provide care in context was unattainable on commencement of their programme. This point was illustrated by Jane during our final discussion:

> Jane:
> ...when I first started...I think you kind of concentrate on the practical, hands-on type things...I think I definitely now look at things more holistically...maybe I feel more confident about the practical side, so I'm able to now look at the fuller picture, whereas before [pause] I don't know. It's difficult to look at things in the whole picture. When you master one part, it's easier to get the whole...
> (Interview 27:p 1)

I asked Jane at this point if she felt that, when she acquired senior student status, she had been given greater access by staff to the information necessary to obtain the whole picture and she felt that this was definitely the case, although she also attributed it, in part, to becoming more assertive in relation to requesting more information.

Good quality care, in Jane's reflection at the end of her three year programme, entailed:

> ...constantly looking for the, at the wide picture, not just the, "Let's get that wound healed" and get them out the door...I think, once you just look at the [pause] the wound, or getting something stabilised and then, sending them back out again, if you don't look at the whole picture, they're just going to be back in again.
> (Interview 27:p 7-8)

The ability to be pre-emptive and pro-active, resultant from acquiring the skills and experience necessary to access relevant information about clients, enabled action to be taken in order to prevent, or minimise, problems for the client (and, where relevant, their carers) subsequent to their discharge from the care setting.

Anne, reflecting upon her programme as a whole, in the fourth interview, felt that she had, in the early stages, considered good care to comprise psychomotor competence but, as she had gained experience in this, she placed less emphasis upon it (Interview 29:p1). It did not appear that she rated it less highly per se, but that, once she felt that she had acquired the required level of expertise, its rating in the overall scheme of care delivery was viewed in perspective, as one

component within a total care package, rather than being accorded undue importance.

The above findings indicate that, prior to attainment of psychomotor competence in nursing skills, it was difficult for students to 'see the wood for the trees' and concurs with the findings of Gray (1997)[10]. Following their acquisition of confidence in psychomotor aspects of care, students were subsequently able to focus more clearly upon the client in a total context, rather than perceiving care as achievement of, sometimes daunting, tasks.

Anne felt that growing confidence enabled her to be more attuned to clients' needs and that, whilst she had previously viewed issues as being fairly clear-cut cases of right and wrong, experience had increased her awareness of the different facets of care and the multi-dimensional nature of each facet. This led her to conclude that, whilst her fundamental concepts of what constituted 'good' and 'poor' quality care were basically unchanged, in many instances there was no single ideal solution to problematic situations within a health care setting.

Sheila, in her final interview, felt that she had become, over time:

> ...less judgemental in terms of em, not jumping to conclusions about why people do things...And realising all the factors and how wrong you can actually be when you judge, when you jump to conclusions. It's something I've noticed again, time and again on my placements, um, for example at [placement name] we had parents who cannot cope with their handicapped child and you tend to, want to jump to conclusions and say, "That's terrible, they should cope [indistinct] love their child". And all this. Where, in actual fact, the reality is, they have able-bodied children that they can't spend time with, you know, not getting any sleep and they're probably at risk of maybe a mental breakdown if they don't get help and, you know, things like that. You realise that there is always, usually always, more to these situations than meets the eye. And I think definitely, when I started my training, I probably would have jumped to conclusions a lot quicker than I would now. Definitely. I, you know, would feel that I would think, well, wait a minute, maybe what I'm assuming isn't actually right.
> (Interview 25:p 112)

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[10] Gray's (1997) study was carried out in the same university (at that time, college) location as was mine, but with students who had undertaken their programme two to three years in advance of the participants in my own study.

Access to background information changed Sheila's initial view of many situations, but when I asked whether she felt that it changed to the extent of finding people's actions acceptable rather than otherwise, she said that:

> I don't know. I can certainly understand why they've done it, a lot better and [pause] wouldn't feel so hard on them, you know? I think, yeh, I would feel sort of saying, yeh, for *them* em, it's acceptable, because you know [pause] they are going to have [pause] even [indistinct] if you listen to them, that em, if they're not going to cope at home [pause] why, really, there's not much point in the child being at home anyway, you know, if they're not going to cope. You know, if it is at that breakdown point, then [pause] what's the point in pushing it? You know?
> (Interview 25:p 13)

Acquisition of the 'wide picture'

The foregoing extract demonstrates that Sheila considered that increased knowledge enhanced her understanding, although not necessarily her endorsement of behaviour. Her acceptance of the situation that she described appeared to be based upon a pragmatic recognition that many life decisions may involve prevention of further harm, or diminishment of risk, rather than achievement of an ideal solution. Sheila went on to say that:

> ...there are so many grey areas I think...you do have to take each situation, you know? It's always different, I think.
> (Interview 25:p 14)

Learning from others: staff

For students, qualified staff in placements were well-positioned to provide role models to which they could aspire. It should be noted however, that 'learning' from staff whose care was, in the students' view, less than satisfactory could also be beneficial. Students could, and did, use their observations of the behaviour of these individuals in order to identify and analyse the aspects of care with which they disagreed and, in doing so, determined that such behaviour was to be avoided in their own future practice. However, whilst learning may undoubtedly occur by the witnessing of unsatisfactory practice, positive role models were of great assistance in facilitating students to acquire some of the complex skills involved in

their work. Anne identified the problems, within her chosen branch programme of mental health, of learning by observation. She commented as follows:

> ...in my own field of mental health...it's very difficult to actually be in an interview as a student, watching a trained nurse interview somebody who is very, very unwell. Um, who might be psychotic, who might be hearing, hearing voices you know, and be very, very distressed. Um, it's a difficult thing to organise because obviously you're not wanting to, to make the distress any worse, but I really value a couple of times I've been able to do that [ie observe] and I really value that because you see how somebody who's experienced deals with it. And the way that you speak to people. The kinds of things that you say. [pause] You know? Per, perhaps in the beginning I would have tried not to say anything which I thought would have distressed the person [pause] any further, whereas it's, it's not always the best thing to do. If you're trying to get information, then by asking somebody about the voices, or you know, paranoia or whatever, may be the best way for you to get the kind of information that you need. And seeing somebody who's experienced doing that and, and the way they choose their words um, is, is really enlightening. For me. I, I've found that really, really helpful. And I've used it since, you know [pause] the, the manner and the, the speech, the content of what you say to, to a patient. I, I've used that since. (Interview 29:p 1)

So, within Anne's area of practice, observation by students of experienced role models could be problematic. The client's ability, if psychotic, to provide informed consent to the student's presence was limited, or absent. It was not the case that such observation was justifiable on the grounds that it might benefit the client and, indeed, the presence of another unknown person might create further alarm in an already distressed individual. It was, however, difficult to acquire knowledge of effective strategies and tactics in the absence of observation. Use of role-play within the university setting could provide some assistance, as could discussion with experienced staff in placement areas, but neither of these provided the quality of witnessing a 'live' performance. Anne clearly considered that the opportunities which were available were extremely valuable in informing her own future care delivery and she had indeed translated her knowledge acquisition into practice. Prior to such observation she might have avoided confronting issues which were of potential, or actual, distress to clients, whereas observation of a skilled practitioner demonstrated the value of exploring such areas, in order to understand and support the patient. The observation of 'role models' was similarly commented on by students as adding to their experience whilst allowing them to remain in a position of relative safety. It was one of the contributory

factors in their accessing of the 'wide picture' and was seen as being a prerequisite for viewing the client 'in context'.

Learning from others: students and friends

Discussion of, and reflection upon, practice with other students, both informally and on a more formal basis within university small group reflection sessions,[11] also enhanced the experience of the individual student. Jane, for example, spoke of a conversation she had with a student who had (at a different time to Jane), been allocated to the same placement area. She started off by saying that:

> Jane:
> ...that's the thing as well. It's *my* perception of what good care is all about...I remember someone saying to me that, the ward that I had sort of raved about, that I really liked, and they said, "Oh, I'd never work in that ward. Because they get the patients up at six o'clock in the morning". And when I thought about it, I thought, "All the patients didn't get up at six o'clock in the morning" [pause], but I kept thinking, "Yeh, we used to get that patient up at six in the morning". I mean, I'm thinking, "Gosh. I never even realised that that might be infringing on what she wanted". She wasn't in a position where she could tell you either way whether it was acceptable to her or not...And it wasn't 'til then that I realised that, well, what I was thinking was perfectly all right, that someone else was, you know, considering a bad thing...
> (Interview 27:p 15)

So, in the above, it was a fellow student whose comments about a placement area caused Jane to question whether what she had taken for granted was, indeed, the best care possible. In reflection upon the situation, she considered that her own perception was, de facto, subjective and that other people's perspective of the same series of events might comprise a very different picture. In some instances this led Jane to alter her own practice, in others to reinforce it.

A rather different instance of accessing the perspective of others was provided by Anne, when speaking about the nature of nursing:

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[11] Students' practice placement allocations included designated study days in university, some sessions comprising reflection, within small group settings, upon their placement experiences.

Anne:
...I think that really good nurses see it as more than a job. It maybe goes back to it maybe being a vocation. This, there is something else to it, em, and it does something [indistinct] and I think that's important as well. Not in the sense maybe that you get kind of a kick out of it, or an ego trip or whatever, but just that there's some kind of satisfaction, for yourself. Em [pause] I was talking to somebody the other day...and they were saying to me, "I wish I'd gone into general nursing because, eh, you get no thanks in this job" [Anne half-smiled and shook her head]...I said, "Well, [pause] perhaps you're, you're giving these people as, you know, better quality of life by trying to do these things for them. Do you not see that as [pause] you know, maybe thanks enough? Maybe they're not articulate enough to express it, but I'm sure there is appreciation there." "No", he says. "Nobody ever says anything" [pause] "I should have gone into general nursing", he says, "at least in general nursing, people are grateful for you [Anne laughed, slightly incredulously] going in, sort of doing things for them". And I thought, well, it's an interesting point of view...
(Interview 29:p 5-6)

So, access to the perspectives of others, whilst it did not alter Anne's own ideas, did increase her awareness that an assumption on her part of shared cultural values in relation to the nature of nursing and of job satisfaction amongst members of the care team could be misleading.

Learning from others: outwith nursing practice

It would however be simplistic, and incorrect, to assume that changes over time occurred purely as a result of contacts and experiences within the educational programme which the students undertook. Concomitant life experiences outwith university and placement settings exerted an effect, as Sheila highlighted immediately subsequent to the above extract.

Sheila:
...It [ie awareness of contextual detail] was something that was brought home to me from a friend, just this week actually [laughed], as well. You know, the situation of why he was behaving the way he was, was, like the reasons for it, were just totally, completely and utterly different. Would never have occurred to me at all, you know? And it was quite, it explained everything, but it was a complete shock, you know? In fact, I would never in a million years have guessed what was actually going on, you know?
(Interview25:p l2)

The above quotation illustrates that any attempt to link changes in perspective over time to discrete areas of the students' lives, such as work, without consideration of the mutual interactions of differing life experiences would be a risky enterprise. It is not, however, my intention to make such claims for the data but, rather, to highlight that the students' identification of changes and constancies within their perspective at work were also resultant from experiences which occurred outwith that sphere. During interviews, I confined my line of questioning to that which related to the care which they had witnessed, and in which they had participated, during their practice placement allocations and it was only if students raised issues outwith that remit, as in Sheila's case, that they were addressed.

Summary: Providing Care in Context

In summary, having said that the core category within the students' accounts was the importance of viewing the client in context and that doing so facilitated the delivery of good quality care, the next sections of this chapter will identify and examine the variety of factors that, within the students' placement settings, constituted the totality of 'the context'. Some categories relate to the role of the individual in care provision, whilst others relate to the organisational framework within which care provision took place. As was emphasised earlier, whilst these categories are discussed here as discrete entities, they were, in reality, inter-related and the sum of their whole was greater than simple aggregation of the individual elements. For this reason, the concluding section of this chapter, and Chapter Five, will attempt to provide a synthesis of these categories.

'The Context'

Location and purpose of care

The location in which health care takes place, and the nature of that care, vary in the substantive detail. The 1992 diploma programme allocates students to a wide variety of placements, in both institutional and community settings. Within earlier programmes the major location of care delivery in placement allocations, regardless of the branch selected by students, was institutional and although

students undertook at least one community placement during their three year preparation for practice the majority of their placements were within hospital settings. The change in focus in the 1992 programme reflected the ideological and actual change within the UK health care system from institutional to community settings for care delivery and was designed to prepare students to work flexibly within and across a variety of care locations. (This shift in the settings in which nursing care provision occurs has not, as yet, been accurately reflected within media representations of nursing, which continue to have as their focus the care of adults with predominantly physical problems being cared for within institutional or primary care settings.)

The locations that the students described and discussed comprised institutions, day centres, clients' homes, hostel accommodation and other forms of supported housing. As will be seen, the interactions between the staff, clients and informal carers were affected by the setting within which care provision took place and by its perceived purpose. As the two are inter-linked, they will be discussed concomitantly.

Care which might be deemed excellent within one care context, might be considered unacceptable within another, one example of this being George's description of his allocation to a mental health unit within a community setting.[12]

> George:
> Like, in an adult placement, if someone shouts and swears at you, then if you turn round and shout and swear at them back, then you're going to get into trouble. Whereas in mental health, because they were trying to teach the people, it was like their own house, and if they were at home and they started shouting and swearing at someone, someone's going to shout and swear at them back. So that if they did choose to shout and swear at them, directed at a member of staff, the member of staff was allowed to turn round and say, give them a mouthful back...There were obviously limits to where that goes, but [pause] that aided the patient's care because the patients knew where they stood.
> (Interview 10:p 11-12)

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[12]The unit housed clients who had previously been detained within a forensic unit, or the state hospital, and functioned as a 'half-way house' in their rehabilitation programme.

George found this treatment of clients acceptable in the light of explanations he had received from staff about the desired outcome of care. As the aim within the unit was re-integration of clients back into the community, the fact that the staff were likely to respond in kind to verbal abuse from clients increased the latter's understanding of the limits to their behaviour and an awareness of the sanctions which certain behaviours would attract within society at large.

Client Understanding

When I asked George whether he felt that clients had a clear understanding of the ground-rules within the unit, and their underlying rationale, he explained that these were clearly stated within the unit's policy document and were verbally explained to clients on their arrival. The unit was not used for clients who were unable to comprehend, or co-operate with, this approach. Clients had a vested interest in compliance because they appreciated that failure to do so would delay or prevent their release from the unit and could, if sufficiently severe, result in their re-admission to a forensic unit, or to the state hospital. In this instance, then, it was the overall aim of care, coupled with client comprehension of, and agreement with, its purpose, which determined the acceptability of the approach.

If searching for a philosophical underpinning, it might be possible to identify George's account as demonstrating a Utilitarian approach, in that the action taken by staff achieved the greatest benefit for the greatest number and that this desirable end justified the means by which it was attained. Whilst George's account could be reduced to this abstraction, he appeared to use a rather more iterative process than any clear-cut attempt at identification of outcomes and means. His acquired knowledge of the individuals concerned precluded the distancing from substantive issues which may be a prerequisite for 'ivory-tower', de-contextualised decision-making.

Benefits and Harms

In discussion and evaluation of their experiences, students provided a detailed weighing-up and balancing of the individual circumstances surrounding decision-making in practice settings. Frequently this involved actual and potential benefits being weighed up against actual and potential harms. However, these

were not benefits and harms as abstractions, but the benefits and harms identified in relation to the specific individuals within that particular context.

Jim provided a clear indication of the above process at work when he spoke of the mental health day centre to which he was allocated during term three. Many of the clients had experienced previous in-patient admissions and identified the freedom from twenty-four hour residential care as beneficial, not least because they were protected from other clients', "...going off in the middle of the night in some sort of psychotic episode" (Interview 7:p 14). Clients:

> ...could smoke whenever they wanted. That was a big thing for them, they had their own smoking room...and they didn't have to come in constantly and ask members of staff for cigarettes, so they did have a bit more freedom.
> (Interview 7:p 15)

This was seen by Jim as important because, not only did it prevent generation of anxiety (and possible behavioural disturbance) in relation to when they would be 'allowed' their next cigarette, but it was also symbolic in a wider sense of their greater autonomy and of being treated, "...a bit more, just more [like] human beings who had a mental problem, instead of being 'a patient'." Jim felt that clients became less insitutionalised and that the atmosphere was more therapeutic than that which he had noted whilst working in some admission units,[13] although he also emphasised the importance of realising the fragility of the clients' independence. On the one hand, it was beneficial for individuals to receive psychiatric care without the stigma which may still attach to hospitalisation for treatment of mental health problems. As Jim described it:

> ..the outside world maybe has a better perception of it [the day centre] than someone who goes into a psychiatric hospital. If you go into a psychiatric hospital, you really are [regarded by society as] sick you know. But, if you go to the day unit, maybe you're not as sick. It's a bit more normal, normalisation, sort of thing.
> (Interview 7:p 17)

On the other hand, however:

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[13]This was experience which Jim had gained whilst undertaking two years of psychiatric nurse training many years' previously, in addition to more recent employment as a care assistant in similar settings.

The bad side of it is that you [ie the staff] have less control and control sometimes is important. People don't want to take their depot injections, or if people want to go off somewhere else...and decide to stay there for a couple of months, and then come back in a terrible state, you don't really have that control over people.
(Interview 7:p l6)

So, here there is a trade-off between greater client autonomy and its attendant benefits and the potential problems which this may engender for what the carers, and society at large, perceive as being the client's well-being, or best interest. Jim summed this up by saying that:

I think the whole point is to lead people to a point where they [clients] start making their own decisions anyway and starting to look for a bit more control in their own life. Ideally. Instead of us, or the national health service, controlling them.
(Interview 7:p l6)

So, assisted and supported autonomy within the limitations of individual clients' abilities appeared here to be the desirable outcome. The location, in this instance a day centre, enabled this aim to be met, as contact could be maintained between the client and the health care providers without the necessity for the former to be under the constant supervision, and disruption to 'normal' life, which hospitalisation entails. Jim's description also places emphasis upon the contextual issues, which were client-specific.

Empathy: 'What *you* would feel like'

Euan described a situation during his mental health placement in term three, in which a client demonstrated uncontrolled and aggressive behaviour and required to be physically restrained by staff, including Euan, and given an intramuscular sedative whilst in a public area (Interview 4:p 4, pp l2-l3). In discussing this situation, Euan weighed up its different aspects. He felt that, although it caused some embarrassment and a degree of humiliation for the client, this was no greater than that which would have resulted from an attempt to move him to a more private location. He decided that:

...it's really all this business about deciding how you would feel in a situation like that and what would you feel like, it, it - what would be less embarrassing to you, you know, if you were the patient? And that, I felt embarrassed for

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the patient, but I couldn't see what else the staff could have done, given the circumstances, coz this was a biggish bloke, you know?
(Interview 4:p 12)

This comment obviously raises the question of the degree to which one can reliably relate one's own experiences and emotions to those of others, and thereby the (in)accuracy of 'empathy' as determinant of care provision for others. There are clearly problems inherent in assuming that the wishes of one individual in a given situation will equate with those of another individual in similar circumstances. However, for some of the students, empathy was undoubtedly used as one, although not the sole, means of processing their concerns.

The acceptability of the use of restraint for the patient was reinforced because:

> ...he was never humiliated subsequently. The charge nurse went in [after the client had become calmer and returned to his room] and spoke to him and said, 'You know, this is just not an acceptable way to behave. You know, if you feel that this is how you have to behave, then come and see us. You know, when this is all building up, come and talk to us, come and tell us when you're feeling like that, rather than let it get to the situation - coz you don't enjoy that, we don't enjoy it, so let's see what we can?' You know? That sort of thing - let's see what *we* can do about it...the idea of including the patient in decision-making and that sort of thing.
> (Interview 4:p 14)

So, in this instance, the action taken by staff was deemed to be acceptable, partially because of the lack of any less unpleasant alternative in the initial stages and, additionally, by the subsequent discussion of the episode with the client in an effort to minimise the likelihood of its recurrence. The idea of partnerships in care between staff and clients was one which was ongoing within students' accounts and, with the proviso that it did not involve staff having 'favourite' clients at the expense of others, was viewed in a positive light. This will be further discussed in the section which addresses the theme of partnerships in care more fully.

'Idealists' and 'Realists'

Within care settings the autonomy and rights of a client may require to be viewed in the light of what are perceived by others to be their 'best interest'. The literal meaning of autonomy as 'self-governing' is often perceived as flexible in instances in which individuals have limited insight into the consequences of their actions or

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inactions (for example, failure to take prescribed medication). In such circumstances, autonomy is frequently regarded as a prima facie principle, which may be over-ridden by principles of beneficence or non-maleficence. Indeed, staff have a duty of care to clients, which is both legal and moral.[14] In addition to this, the autonomy and rights of one client may have to be viewed in relation to those of other clients. This increases the complexity of the moral decision-making required of staff in some care settings. Conflicts may exist between staff, in relation to the importance accorded to autonomy vis a vis beneficence.

Sheila provided a clear explanation of the process of balancing autonomy against benefits and harms in her discussion of the care which she saw given in term eight in a hostel for people who had a learning disability. It was run by the social work department and this had provided Sheila with interesting insights into the differing approaches adopted by nurses and social workers to client care.[15]

Sheila differentiated between what she termed the 'idealistic' approach advocated and implemented by some staff and the 'realistic' approach of others (Interview 19:p 16). She identified the former approach as that more commonly displayed by social workers and the latter by nurses. The former approach was orientated towards provision of autonomy and choice for clients, with which Sheila was in agreement, but she felt that this was taken too far by the idealists in relation to care for clients who lacked insight into the consequences of their actions. She described in detail (Interview 19:pp 16-18, p 21) a client who had a longstanding alcohol problem and who, if given the freedom to drink without restriction (as he had been in his previous residency within a community home), ended up sleeping rough. Sheila commented that:

> [the client was not someone]...who could have, like, defended himself, you know? I mean, anybody could have taken advantage of him, you know, in any way. [She had also identified him as having no sense of danger when

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[14] This is supported in law and by professional regulatory bodies, such as the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC). It is also implicit, or explicit, within most contracts of employment.
[15] These were discussed earlier (Chapter Three), in relation to the importance of ascertaining the students' own definition of the concepts that they described and the way in which an assumption of shared meaning may, in some instances, be erroneous.

crossing roads, even when sober.] So, that was why he was moved to the hostel.
(Interview 19:p 16)

Upon his arrival, some staff considered that a programme should be implemented, whereby he could go to the pub in the company of other residents and staff (who could thereby exercise some control over the amount that he drank), but that he should not be allowed to go out drinking on his own. Other staff, however, disagreed with putting any limits on him, saying:

...that's his choice, to drink as much as he likes, you know. Regardless. So, there was that sort of [pause], to me the difference between the realistic and the idealistic. That's how I would see the divide. Personally.
(Interview 19:p 17)

Sheila said that, in her own view, some limitations were required and, when I asked for her reasons, she explained that:

...if he's in our care, then we're responsible for him and if anything happens to him it comes back to us. And we're not providing a good duty of care by [pause] you know, just letting him. We know he's going to come to harm and he doesn't have the sense, insight, to understand that...in an ideal world it would be lovely to give him the choice to go out and do what he wants, but you know, there's times when you just can't do that [pause] for people, you know?
(Interview 19:p 17)

Sheila moved on from discussion of the impact of the client's actions upon himself, to the effects which his behaviour could have on the other residents, saying that:

...you've also got to think of the other people in the hostel. He could be coming in, drunk, and be in a really bad mood or something and, you know, affect the other people, as well, you know. And, there had to be some consistency...because even the other people might see [client's name] do this and decide that was a good idea for them to do it, you know? [D Yeh] So, yeh, so that's what I mean by idealism and realism.
(Interview 19:p 17)

So, here, Sheila weighed up the benefits of full patient autonomy, but decided that, for this particular client, unrestricted freedom was unrealistic because the potential

harms, into which he lacked insight, precluded this. These were harms both to himself and to the other residents within the hostel, although the former were the ones to which Sheila accorded quantitative and qualitative precedence in her discussion. For clients who lack insight, or whose behaviour, if unrestricted, may cause problems for others who are in need of care (she at no time accorded importance to the impact on staff of clients' behaviour) some limitations upon their behaviour may require to be set.

Sheila considered that a consistent approach by all staff in relation to care of individual clients was important and she provided further discussion of the problems engendered by the conflicting approaches of the idealists and realists in relation to this particular client. His key worker, prior to going on holiday, had identified the need for the client's alcohol intake to be restricted but, because of the client's lack of financial resources, had agreed that he could, with one of the other workers in the hostel, use a home brew kit. However:

> ...when she [key worker] went away on her holiday for two weeks, when she came back, they'd made 40 pints - and the man had drunk them all [laughed - but not really amused]...Which is very, extremely inconsistent. And I don't think it does him any favours. You know, 40 pints in a fortnight, for somebody who's supposed to be, you know, had an alcohol problem, is hardly, you know, very good.
> (Interview l9:pp 20-2l)

Sheila went on to say that, for care in the community to work, those implementing it require to understand that everyone has limits within which they must operate in life. She also made the interesting comment that the consequences of actions such as those which she described above perhaps mattered less in the past, when they occurred within the secure environment of an institution, in which clients were (at least in theory) protected from physical hazards such as road traffic and human predators to a much greater extent than is possible within a community placement.

What Sheila also identified was that, although she considered herself to be a realist, she felt that having contact with idealists was beneficial.

> ...I think the folk who were idealist did make you think a lot, more, just making sure I didn't do things for the clients that they could do for themselves. And got that more into focus for me, just to, to check myself, as it were...[but]...For me personally, you know, they didn't take account of all

the factors. They were so pro-choice as it were, that they just didn't take. They were just concerned about making sure the client had his or her choice, no matter what the consequences.
(Interview 19:p 20)

At the end of the day, although she felt that interaction between the two approaches was beneficial to proponents of each, she remained firmly within the 'realist' camp.

Care in the client's home setting

Some of the students' placement allocations were with community nurses, whose job entailed caring for clients who were resident within their own homes. Their clients' care requirements stemmed from problems which were ongoing, but did not necessitate an institutional setting. The students perceived that this created a rather different relationship between the nurse and client. Jane's account of her placement within a health centre, two weeks of which were spent with the district nurse and the other two with the health visitor, serves to highlight some of the issues involved. That the care was delivered in the client's home did not necessarily individualise it per se, but the sustained contact between the client and carer and the absence of competing demands within the immediate vicinity, such as those present within an institutional setting, ensured undivided attention for the client and enabled a rapport to be established and supported. Jane said that:

> ...they [district nurses] just take the time to ask about other [pause], whether it be during the dressing or whatever, but to ask about the other elements of the person's life, you know?...I don't know if it's, if it's the different environment, or because it was more relaxed because, the patient was more relaxed in *their* environment, or what...Maybe when you don't have the same [pause] feel for underlying problems on the wards, you know? A bit of a time thing, or an environmental thing.
> (Interview 18:pp 18-19)

When I asked Jane to identify the factors that made the care seem better than that provided within a hospital setting, she considered that, although the nurses worked on their own, there was a multi-disciplinary team approach which worked well within the health centre and, whilst the nursing staff carrying out the care did so on their own, they reported back to one another at pre-arranged times, in order to discuss progress and problems. Staff did not have clients to whom they were invariably allocated, rather the system was designed so that clients became familiar

with all the nursing staff. Jane felt that this enabled staff to share their views and expertise on the care of each client with one another and, additionally, prevented the client becoming insecure in the absence of 'their' nurse. The expertise, both theoretical and practical, of nursing staff was also identified as a factor, all being employed at Grade E or above.[16]

Another salient factor which Jane identified was that, in contrast to care within institutional settings, the district nurses worked on their own and, whilst community care is available for some clients on a twenty-four hour basis, this constitutes the exception rather than the rule. It is therefore frequently the case that, if the nurse working with the client in the community does not carry out all the care required, nobody else will do so. There was then, in Jane's view, an additional responsibility placed upon staff in ensuring that the quality of care was satisfactory. Whilst such responsibility is also present within hospital settings, it is, in Jane's view, less clearly defined and the accountability for care is less the remit of specific individuals but is, rather, disseminated over a much larger group of nurses than is the case amongst the district nurses. As Jane commented:

> ...Maybe, I mean, that's why the holistic care doesn't get taken on the wards, coz there's someone to, someone'll clean up at the back of me, but that shouldn't be the attitude...
> (Interview 27:p 14)

According to Jane's comment, the occurrence of holistic care is by default, ie you only *have* to care for the all the client's needs in the absence of someone else to take over where you leave off. Although Jane did say that she did not consider that this *should* be the attitude, the impression given here of the concept of 'holistic care' is perhaps a reflection of the constraints and realities of practice, despite the emphasis placed in nursing rhetoric upon each and every client being accorded 'holistic care'.

Whilst Jane perceived that, within the community setting, the added responsibility and accountability of staff was positive, in that it permitted, and indeed required, a greater involvement with individual clients and a higher degree of autonomy in

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[16]ie senior staff nurse posts

care delivery than was possible within a hospital setting, it did not come without a cost. As Jane explained:

> ...I mean, I'm making it sound like the district nurse has got time to sit and, you know, if these district nurses, if they did take the extra time, which they felt they wanted to have, they felt it was beneficial as well, their day did go on longer...what I'm saying is, where a shift would finish at half three or something [in a hospital setting] and you'd maybe get away at twenty to four, the district nurse would end up staying until five, half five, you know what I mean?...one-to-one relationship and you *want* to stay and you *want* to help them. And [pause] too, even if you just wanted to leave, I don't think you could because you couldn't, I'm not being nasty, but you couldn't like [in hospital], the patient's going home in a couple of days anyway and I'll never see them again, you know?
> (Interview 18:p 21)

Jane described a woman who was terminally ill and who had discharged herself from hospital because she wanted to be in her own home. This necessitated the community care team organising, at short notice, equipment, controlled drug analgesia and nursing care. As Jane described it:

> ...Well, this had to be set up and this was like, at quarter to five on a Friday afternoon. Em [pause] and I stayed coz I was due to finish at five, or something like that and she [district nurse] said, "Do you want to stay?" And I said, "Oh yeh! I want to stay". Coz this, I mean, this is part of your job. And at quarter to five on Friday afternoon, you know you can't [leave]. And if they [district nurses] didn't do it? [Dorothy: Yeh. Nobody will.] Nobody will, yeh. [pause] Em, so that was really good...
> (Interview 18:p 22)

So, in Jane's view, nursing involves commitment and may be most satisfying when the relationship is sustained over time and when contact and responsibilities to the client are ongoing, rather than time-limited in the clearcut way which occurs within an acute care institution. This, however, came with the proviso that, in order to foster such a relationship, it might be impossible for the nurse to leave work at the official end of a shift. That this did not appear problematic to Jane was rather in contrast to her comments at a later date (Interview 27:p 12), at which point she said that, "...I don't think we should push ourselves in nursing because that's not getting rid of the problem that you've not got enough [pause] members of staff...". She acknowledged that, whilst it may not always be possible to finish work on time within a hospital setting, leaving is not complicated by the

knowledge that the client will receive no assistance in your absence (Interview 18). If using a frame analysis approach here, it may be suggested that the hospital and community care frames provided different implicit, as well as explicit, 'rules' for all participants within them.

Although 'paperwork' emerged as a theme which will be accorded exploration in a section of this chapter, it is worth noting at this point that, whilst Jane's community placement was identified as being excellent in care provision and in team co-operation, nonetheless:

> Jane:
> ...the care-plans weren't, careplans as I imagine they should be written...the care-plans weren't very - up to scratch.
> (Interview 18:p 19)

Similar comments to the above were made by other students, ie the quality of care delivery and the quality of care documentation were not contingent. Indeed, as identified by Jane, some areas in which care was considered by the students to be of a high standard were those in which its documentation was sketchy, whereas in some of the areas in which the quality of care delivery was deemed to be unsatisfactory the paperwork had at least the appearance of being in order. In some of the latter instances, however, the care documented as given had not, in fact, been provided.

Providing 'care in context' in community settings

The students' perception was that caring for clients in their own homes entailed the establishment, and maintenance, of a more equal relationship between client and nurse than was possible within institutional settings. The client had the option to refuse access to their property and this entailed that the nurse had to request entry in a way that was not required within an institutional setting. That the client was on their own home ground provided them, in theory at least, with greater security and confidence than they might experience in unfamiliar surroundings. For the nurse, constant reminders of the client as an individual were evident within the environment.

Whilst the concept of partnerships in care will be discussed per se as a theme within a later section of this chapter, it is relevant to highlight at this point development of what some of the students perceived as partnerships in care between client and nurse. The reduction, in overt ways, of the power imbalance between client and carer appeared, in the students' view, to make the relationship less unequal than might be the case within an institutional setting. That this imbalance existed was emphasised by Euan, when he said that:

> And I also feel that...it's a fallacious assumption that some people make that it's an equal relationship. It's never an equal relationship between patient and nurse. But you have to try and make it as equal as possible...
> (Interview 24:p 1)

The care *needs* of clients tend to ensure that the balance of power remains in favour of formal care *providers*. However, when such care provision occurs within the client's home territory, this may serve to ameliorate the inequity. Reminders of the client's individuality, as manifest by their surroundings, may increase the likelihood that the nurse perceives them as someone who cannot be treated as other than a partner in care provision. As is discussed in a later section of this chapter, depersonalisation was associated by the students with poor quality care and appeared to be facilitated by situations in which the patient was precluded from being seen as a fully-participating member of society.

The foregoing accounts of caring for clients in their own homes provide evidence of the fundamental importance of the core category, ie that of 'providing care in context'. When delivery of care takes place within the client's home the individual may more readily be placed 'in context' than is possible within an institutional setting and it is consequently easier to assess at first hand their ability to cope and to plan their care accordingly. It is also comparatively easy to evaluate the effectiveness of the care provision; when providing care within a hospital, it is sometimes problematic to predict the extent to which the continuation of a care regime will be feasible within the client's home environment.

'Boundaries' to contextual considerations

Having described and discussed some of the contextual considerations which the students regarded as being of importance in relation to the location and purpose of care, it should be stated that they also identified boundaries, beyond which any

considerations of context were irrelevant. Clear demarcation lines were identified and were breached when clients were verbally and/or physically abused. Certain client groups were more likely than others to be the subject of such behaviour and this will be discussed in greater detail in a later section of this chapter.

Boundaries existed which, if exceeded, resulted in care being deemed unacceptable by the students, irrespective of any other factors (for example location, purpose, or organisational constraints such as inadequate staffing levels). Anne spent her mental handicap placement during term five in the day centre within a large institution. Patients from wards within the institution spent a varying number of days per week either within the day unit, or on visits outwith the institution. Within this setting Anne found that:

> ...the way in which some patients were spoken to by nursing staff em [pause] was really appalling...it was almost a form of abuse, you know, to sort of shout at people and to get really very angry with people, which I noticed on a couple of occasions. Um, just losing your temper, you know.
> (Interview 13:p 1)

She described a patient who was very repetitive in his speech and actions and, on one occasion:

> ...the care assistant just lost it.[17] And, and shouted and pushed him and eh, sort of, 'Get out of here!' and 'I'm fed up to the back teeth with you'...and, actually, physically pushing him away...
> (Interview 13:p 2)

In this instance the patient had some awareness of the way in which he was being treated, although he lacked the ability to make any complaint, but, when I asked whether his ability to comprehend events constituted a factor in deciding whether his treatment was viewed as acceptable or unacceptable, Anne emphatically declared that patient awareness, or otherwise, did not make any difference.

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[17]Although it was an unqualified member of staff who behaved in this way, it was not an isolated incident within the placement area. The qualified staff were aware of the behaviour, but did not (even although Anne discussed it with her mentor) appear willing to take any action. The power which individuals such as this care assistant may exert within a care setting, and the impact which this may have upon the quality of patient care, is further discussed later within this chapter.

Anne also described a patient whom she went to collect each week from one of the wards and with whom the staff did not appear to communicate.

> Anne:
> ...the nurse never spoke to her and said, "Well, here's Anne come to get you to take you to, to the bus, or to take you to the house to do something with". There was no [pause] no speaking to her, It was just, "Here's her coat" and away she went. It was like she didn't exist there and eh, it was the same when I brought her back. It wasn't... "Oh, hello! You're back, how did you enjoy yourself? Was it good?"...Nothing! Just, "Right", but, to me [ie not to the patient] "Right". And just ushered along. I mean, she wasn't greeted at all and I just wonder how far this went into the pattern of the whole day.[18]
> (Interview l3:pp 2-3)

Speaking later within the same interview, she spoke of another boundary violation. The charge nurse in Anne's adult physical health placement was identified by her as being excellent in many ways, for example in her theoretical knowledge, accompanied by technical competence and in her willingness to be involved in direct patient care and to answer students' questions and provide them with explanations. On one occasion however:

> ...there was a particular patient, who was dying and she was aspirating, doing a lot of groaning and, you know, trying to spit the fluid. [pause] An awful lot of groaning and moaning, and she'd been like this for quite some time. And, eh, the sister[19] came up to her one day and said, in a very loud voice, you know, "Will you stop that noise. You're disturbing other patients". And, I mean, this woman was dying, she died the next week and, I mean, you're gobsmacked when you, when you see this.
> (Interview l3:p 6)[20]

Similar comments to the above were made by Alan in relation to his learning disability experience during term five. He spoke of the nurse in charge who swore at clients whose comprehension was limited and who, in any case "...would be

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[18]This was a patient with whom Anne developed a rapport: it was not the case that she was a patient whose learning disability was so severe that communication, when attempted, was unsuccessful.

[19]Although the term is now officially 'charge nurse', in some areas (usually in adult physical health) 'sister' continues to be used as a form of address.

[20]The student's way of coping with this incident, the attitude of the staff nurse with whom she discussed it (but who took no action), and the possible reasons for the sister speaking as she did, will be explored later within this chapter.

used to that, you know? They would just, it's probably been going on for years..."
(Interview 11:pp 13-14). Alan was emphatic, when I asked whether a client's
insight, or lack of it, made a difference, that it did not and that such behaviour was
unacceptable.

The client's conscious awareness, or otherwise, of the care that they receive does
not, then, appear to be a factor, let alone a determinant, as to whether it is
regarded by students as acceptable or otherwise, although instances in which the
client displayed such awareness appeared to be viewed as marginally worse.

The existence of 'boundaries' to contextual considerations does not, however,
conflict with the analysis that *providing care in context* is the core category within
my study. It must be borne in mind that the 'boundaries' described by the students
existed *within the context* of care provision for individuals who are physically
and/or mentally vulnerable. For the students, care provision *in itself* constitutes a
context which precludes any practice, under any circumstance, that is detrimental
to clients.

Boundaries to client behaviour

Also regarded as unacceptable were certain behaviours by clients towards nursing
staff, although in these instances the individual clients were not accorded total, if
any, blame. It was, rather, the system within which care delivery took place, or
the actions (or inactions) of health care professionals which were perceived as
primarily culpable. This was evidenced, for example, in Euan's account, in which
staff accepted violence by clients as an occupational hazard, rather than
considering it to be unacceptable and exploring measures to prevent its
occurrence.

Euan identified the limits to the behaviour that staff should be expected to tolerate
from clients, although this was spoken of in relation to the welfare of the client, in
addition to that of the staff member. During his mental health placement in term
three, a female client had told Euan that she was going to accuse him of rape. He
had remained calm and the patient had rescinded her accusation, saying that it was
meant as a joke. He had reported the incident to the nurse in charge immediately
but felt that, although staff had been sympathetic to him, had appreciated how
vulnerable he had felt, and had spoken with the client re the unacceptability of

making such unwarranted accusations, the only action taken was that a written record of the incident was entered in her notes (Interview 4:p 6). Although Euan said that this was the first time that it struck him that people who have a mental health problem may be pleasant or unpleasant as individuals, independent of their illness, he also made the point that the clientt herself was vulnerable and that, had anyone sexually assaulted her, he wondered how seriously her claim would have been taken in view of her sexually explicit behaviour, both towards himself and towards one of the male clients. So, in this instance, there were limits to student tolerance of client behaviour, even after the mitigating effects of a mental health problem were taken into account.

Euan raised the issue of unacceptable client behaviour again, during the interview which took place during term nine. On this occasion it related to client assaults on staff, which he felt are viewed, within mental health settings, as being an occupational hazard for nurses (Interview 20:p 4), rather than something which should be taken seriously. During one incident Euan temporarily lost consciousness, following an assault by a male client who had a past history of violent behaviour, including sexual assault upon a female client and a female nurse. No charges had been brought by the hospital on the assaulted female client's behalf, nor on that of the female member of staff. He considered that the failure of staff to take action in relation to the assaults resulted in the perpetrator feeling that he could get away with any sort of behaviour under the aegis of his mental health problem, which Euan regarded as not being in the client's own best interest (nor in that of any of the injured parties).

Euan felt that the medical staff, who were aware of the incidents, should have acted but that:

> ...this maybe sounds unnecessarily cynical but, do we really, are we saying that it's only when a doctor's assaulted that this, that something's done about it? One suspects it is. Em, you know, psychiatrists and psychologists don't see it as part of their, the risk of their job that they're going to be assaulted, and I don't think nurses should either, you know. We should *not* take that as acceptable you know.
> (Interview 20.p 5)

Euan felt that incidents such as this were taken insufficiently seriously when reported to the university staff and that the reason for inaction was "...because

they've [ie hospital and university staff] got into the culture of just seeing it as a risk." (Interview 20:p 6). This account was later slightly qualified, however, when he said that:

> ...to be honest, I felt that it was the medical staff who were reluctant to take on board these issues. Because I certainly felt that, on any of the ward rounds I've went to, the nurses constantly hammered this point home. They felt that this was an issue, but the medical staff just were not interested in taking it on board.
> (Interview 20:p 7)

This had made Euan feel angry because:

> It's the old business about 'Doctor knows best', you know. And I'm sorry. I think, especially in somewhere like mental health, where we're observing the patient far more than they are. I mean weeks, if not months, can go past without these doctors seeing these patients. They should spend much more time listening to what we have to say.
> (Interview 20:p 7)

So, in two of the interviews, Euan identified client behaviours that he viewed as unacceptable and criticised the phlegmatic attitude of staff, in particular medical staff, in relation to the issue of clients' violence towards both nursing staff and other patients. He referred to one placement, in which a partnership approach between nurse and client was fostered. Within that unit clients were advised that there were boundaries to acceptable behaviour and, because the staff's approach to clients was respectful of them as individuals, they responded positively to this (Interview 24:pp 4-5). Euan's remarks, however, also served to highlight the continuing medical dominance of health care provision and the lack of power, or even influence, which nursing staff, despite their sustained contact with, and concomitant knowledge of, clients are able to exert in such situations, even when their personal safety, and that of others, is at stake. The issue of medical dominance will be further discussed later, in relation to both its overt and covert effects upon the quality of care that clients receive.

It can be seen, then, that although certain behaviours by clients towards nursing staff were regarded as unacceptable, it was the case that, when these occurred, individual clients were not accorded total, if any, blame. It was, rather, the system within which care delivery took place, or the actions (or inactions) of health care professionals which were perceived as the underpinning problem.

The role of the individual

Within the interactionist approach outlined in Chapter Three individuals are active participants in creating meaning in any given situation. Within this chapter the extent to which symbolic interactionism is explanatory of the data within my study will be explored and discussed, as the students' accounts suggest that, whilst symbolic interaction provides the underpinning for a grounded theory approach, its use requires to account for the 'macro', as well as 'micro', situation.

The following section will explore the students' perceptions of the effect which individuals, both solo and as members of groups, may have upon the provision of client care. Examination of the interview data indicates a tension within some of the accounts, in that, although students frequently asserted that the individuals responsible for care delivery were those responsible for its quality, it became equally clear from their descriptions that many factors outwith the individual, or groups of individuals, facilitated or inhibited the care which it was possible for them to provide. These influences were sometimes explicated by the students, but on other occasions emerged as a backdrop to the account, as opposed to being highlighted within it. As the role of the individual is explored within this section, it is my intention to identify these external factors, to discuss their potential effects and to examine changes over time in the emphasis placed upon them by students.

That the students placed the onus for quality care delivery upon individual members of the permanent staff in placement areas was of particular interest because, in relation to their own status as students, they regarded themselves in the early interviews as being powerless to influence events. As was identified briefly within Chapter Three, some students felt unable to vocalise concerns to placement staff about what they perceived to be unacceptable nursing practice. This was due to anxiety about the repercussions that they might experience from placement staff as a result. In addition to the risk of unpleasantness at the time, some students feared that they might receive a poor assessment from staff upon completion of their allocation. Failure to achieve a satisfactory placement report had the potential to halt a student's progression within the course. In relation to themselves as individuals, some of the students noted considerable change in their attitudes over time, as by the end of their programme they felt able to speak out, regardless of potential, or actual, reprisals by placement staff. That organisational

factors might exercise a similarly constraining effect upon permanent care staff was not fully acknowledged until the later interviews. This point will be discussed more fully in relation to changes in the students' perceptions over time.

It was the case, then, that the role that the *individual* played in relation to care provision was highlighted and accorded great importance by students. The potential for care to be of a high quality was greatly enhanced when individuals did not work in isolation, but co-operated as members of a team although, as will be seen, the effect on patient care of a 'team' approach was not a foregone conclusion.

The role of the charge nurse

It would seem at first sight, perhaps, that the key individual in determining the quality of nursing care would be the nurse in charge. As was discussed earlier however, identification of what 'nursing' comprises in some areas is not clear-cut, at least to the students, although their accounts do indicate that this uncertainty was, on occasion, shared by qualified staff.[21] Adult physical health areas, including care of the elderly, appeared to be the placements in which students felt clearest about the role of the nurse,[22] high priority being accorded within these areas to the accomplishment of psychomotor activities. These are readily identifiable by their physical nature and observable outcomes, as opposed to implementation of psychosocial care, for example, which is not. It was the case for all the students within this study, however, that they felt that psychomotor aspects of care were accorded a higher status in the scheme of things than was warranted, and that this precedence was sometimes maintained at the expense of psychosocial care. That the lack of emphasis on psychosocial aspects of care was keenly felt was evidenced by the fact that two of the students who, in their first interview, had remained undecided as to their choice between adult physical health or mental health for their branch programme, decided on the latter in light of the low priority placed upon psychosocial care in the former.

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[21]For example, Euan's comments about the role of the community psychiatric nurse, cited on page 9 within this Chapter.
[22]These are, of course, the areas most commonly represented as 'nursing' in the media.

In the students' accounts, the impact of the charge nurse upon the philosophy of care and its manifestation in practice appeared to be greater in adult physical health than in mental health and learning disability areas, in which the personalities of other team members, either individually or, more commonly, collectively, exerted the more powerful influence in the students' construction of events. Sheila's experience, although rather more negative than that of some other students, will be used as a substantive example, as she provided comments which encapsulate some of the key points within the experiences described by the others. It was the charge nurse in Sheila's adult placement who (although clearly outweighed in numbers by the other members of the nursing care team) was the one whose views carried authority as to the structure and form which care should take[23], even although the qualified staff appeared to disagree with at least some of its aspects. The placement was an extremely busy and short-staffed medical ward, with many patients physically dependent upon nursing staff. One of the qualified nursing staff had been in tears on two occasions when Sheila was present, as a result of stress engendered by the high workload, but when Sheila had discussed this with her mentor she was told that the charge nurse:

> ...doesn't tolerate folk being upset because of stress. She sees stress as a sign of weakness and she's totally unapproachable on that matter...I'd said to my mentor, 'Oh, So-and-so was in tears the other day and within ten minutes she was out in the ward again doing the drug round as if nothing had happened'. And I said I thought it was awful and all this and she said, 'Oh yeh, but it's because the sister, the way sister is, you know,' and she said, 'Oh, sister just doesn't tolerate that and em, you know, that's why we don't approach her about anything'...
> (Interview 14:p 19)

It was interesting that Sheila identified this charge nurse as being, "...a very traditional sister", which she elaborated upon as follows:

> Sheila:
> I mean, I know any time she saw me [pause] stood at the nurses' station looking at, or reading something, you know. She asked if I'd *do* something ie physically, something I could physically do, with my hands, you know?

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[23]It may seem, at first sight, obvious that the person who is invested with the title of charge nurse will be the one who 'calls the shots' but, as seen from students' experiences in areas other than adult physical health, this was far from a sine qua non.

[laughed] And I felt that that was very telling, you know?...always *doing* something, the ward always having to be spotless, you know? Which I know is important, you know, and em, fussiness about the ward being so clean and all, and em, everything being tidied up. The idea of getting stuff done in the fastest time, very regimented routine...and always making way for the doctors, you know?...people to be looked up to and worship the ground they walked on you know? Things like that.
(Interview 14:pp 11-12)

This 'traditional' approach impacted upon the whole approach to patient care within the placement and, whilst Sheila acknowledged (as did all the students) the importance of psychomotor competence in the delivery of physical care and the maintenance of a clean environment, she felt that this approach accorded little importance to:

...the patients' feelings and just...it was so busy with just the practical, almost housework, you know, that em, I don't know. You just didn't get to know anybody and em, you know, just see a bit more about why the patients were in. You missed out on the patients really, you know...all orientated for the organisation of the ward rather than orientated toward the patients...the whole structure and organisation of things, em, prioritise, and the patients just had to fit into that.
(Interview 14:p 12)

In this area, then, the patients appeared to be regarded by the charge nurse as a rather untidy and unpredictable inconvenience whose presence impaired the smooth running of the ward and necessitated control by means of a rigidly enforced framework in order to ensure minimum disruption. It might be tempting to consider that this particular charge nurse constituted an anachronistic time-warp, but similar accounts of individuals in charge of adult placement areas were echoed by other students.[24]

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[24]It is difficult to ascertain how representative this approach to ward management is. I was aware that the students who provided the most lurid accounts of this regimented approach had undertaken their experience within the same large teaching hospital. It is arguable that students from other areas within that hospital, or from other hospitals within the placement allocation area, may have had different experiences. The aim in this study, rather than speculation as to how 'typical' the area is, is exploration of the students' perceptions of the origin, perpetuation and ramifications of such an approach to client care delivery.

It is of interest that the charge nurse's approach was not held by the other members of staff, Sheila's mentor for example, stating that she wished that there was more time available to speak with patients. Sheila supported this by saying that she felt that the lack of communication between staff and patients was due to the ward being so busy and short-staffed that it was scarcely possible to ensure that adequate physical care was provided. Indeed, Sheila identified several occasions on which it was not. She and another junior student asked advice from a registered nurse as to the type of dressing appropriate for a patient's wound but, as they did not receive this, despite repeated requests, they felt obliged to select a wound dressing that they thought might be suitable. This subsequently transpired to have been an inappropriate choice (Interview 14:pp 5-6). On another occasion, Sheila was bedbathing a patient when the registered nurse who was dispensing medication came behind the bed-screens with an injection for the patient, which she left Sheila to administer, although she had not participated in any of the procedures necessary to ensure that the drug was one which had been prescribed for the patient. Although Sheila was fully aware that she should not have given the drug under these circumstances, as she described it:

> ...she [staff nurse] was away before I could get a word, you know...I gave the patient the injection because I felt by that stage in the placement I thought, if I objected to anything like that, I thought I was contributing [to the burden of stress on qualified staff]. The ward was so busy, the staff were always really stressed and I felt, you know, to start objecting to it would only have contributed to...the stress of her job. Which, em, from what I'd seen was quite understandable, you know...basically I just felt that, well if I don't do this then she's going to get upset because, and in fact later on that same day she did get upset and you could even tell that she was not herself, you know? And em, you know, you end up, you just do it because, you know, you feel like you're useless. I had such a sense of being so useless in such a busy ward...
> (Interview 14:p 4)

As described by Sheila, the above was a clear and unambiguous example of bad practice on the part of the qualified nurse (and of the student, although it is arguable that the greater accountability for the behaviour lay with the registered nurse). In order to minimise the risk of error, medicine administration requires that the nurse who administers medication to a client is the same individual who has previously checked and dispensed the drug and verified the client's identify. The subsequent signature on the prescription kardex indicates that the signatory

has witnessed the client taking or, in the case of an injection, being given, the medication. That Sheila was prepared to take the risk of administering a drug by injection, without supervision, and in ignorance of its action, is indicative of the pressures that she experienced during her placement. In the re-telling of the event she was clearly distressed by the fact that she had known it to be wrong, but had nonetheless carried out the registered nurse's request, in order to prevent an escalation of an already stressful situation for all concerned.

As noted earlier, it was of interest that, although the qualified staff within the ward carried the weight of numbers:

> Sheila:
> ...it seemed to be very much the sister [who] set the tone of the ward and that seemed to be quite definitely clear. And she wasn't a good, a good leader, you know what I mean, a good organisational person. She wasn't...she was outweighed in numbers, but for some reason, her ways stuck so, that was it. Which makes you think I suppose about, you know, how much nurses do put up with the regime and that, just for the sake of putting up with it. It is, it made me think about things...what's the point in being a nurse if you're going to put up with that, you know?
> (Interview 14:pp 18-19)

There were, however, limits to the tolerance of the permanent staff and the registered nurse who was Sheila's mentor had decided to move to a post elsewhere as a direct result of her experiences within the ward.[25]

Sheila's experience highlighted the negative impact that the charge nurse could have on the delivery of client care, whereas George's perception of the charge nurse in his adult care placement was more positive. This individual was unintimidated by the medical staff, being unafraid to challenge them by saying, for example:

> George:
> ..."Well, I don't believe that what you're doing is right for my patient" and she took it very, very personally. [D: Mhmm] Em [pause] *her* patients and her staff [pause] were everything to her...[and she] encouraged them

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[25]It can of course be argued that the action of Sheila's mentor constituted a passive, rather than active, means of protest, as neither she nor the other staff had officially registered their dissatisfactions.

[patients] to voice their rights [both to medical and nursing staff].
(Interview 23:p 15)

As a consequence, in George's view:

...The atmosphere that came out was [pause] that everybody on the surgical
ward worked for the patients.
(Interview 23:p 17)[26]

The approach of the charge nurse in Sheila's placement, and the dynamics of
similar situations described by other students, can perhaps be best understood by
examination of the work of theorists. The influential and much-cited work of
Menzies (1960) examined the management of the anxiety generated within nurses
by the traumas attendant upon nursing as an occupation and the measures, such as
task-orientation and concentration on the physical, which may be taken in an effort
to ameliorate this. The approaches utilised by charge nurses such as the one
described by Sheila were not identified by students as being a means of anxiety
reduction, but in the more general way of being a means of coping, or of being
ingrained within a nursing approach now outdated. Such strategies may, however,
be viewed as a means of survival in a threatening, and potentially overwhelming,
environment. In relation to the management style adopted by the charge nurse, it
would be simplistic to attribute this solely to the personal qualities of the
individual concerned, or to some defective management style adopted by women
in nursing (or elsewhere).

Davies (1992:pp238-247) cogently describes what she terms 'coping management'
and explores the underlying dynamics of its occurrence and prevalence within
nursing. Coping management comprises the strategies which are likely to be
adopted by a group of employees if issues which are of importance to them are
ignored by those responsible for resource allocation. Davies proposes that such a
group are likely to close ranks and look inwards to their extant resources, rather
than requesting, let alone insisting upon, the assistance which they require.

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[26]Apart from being of interest in illustrating the ability of this charge nurse (who
was in her forties and had been in post in the same ward for many years) to
challenge the authority of medical staff, what is also noteworthy is her use of the
personal pronoun when speaking of the patients and staff members. Whilst it
precludes a distancing technique, it provides an example of overt inclusion, and
appropriation, of others as in some way belonging to her.

Although this results in praise from those responsible for resource allocation (and thus constitutes a form of positive reinforcement which is likely to perpetuate the behaviour) it has, as can be seen from Sheila's account, deleterious effects upon the carers and those for whom they are responsible. Reliance upon coping management necessitates heavy demands upon staff, both in physical and emotional terms, resulting in manifestations of stress such as those described by Susan. The complexity of the arrangements required to 'keep the show on the road' decreases their intelligibility to those outwith the immediate area and this, Davies argues, increases the likelihood of organisational neglect. As she points out (1992:p249, note 5), neglect, although less readily acknowledged as such, involves the exercise of power as much as does a decision to coerce or compel. She suggests adoption of a gender relations (as opposed to gender attributes) approach and points out that the gender divisions within the health care labour force derive from a masculine worldview which accords authority and status to positions held by men and devalues those to which women are relegated.

Gamarnikow (1978) identifies the reflection of the Victorian domestic triad of man/woman/child in that of the doctor/nurse/patient relationship within the public sphere. Historically, health care within the UK since the mid 19th century has been organised within a framework which accords medical staff (traditionally, and until relatively recently, predominantly men) agentic and dominant status over the other two groups; nurses (then, and now, predominantly women) occupying a role as providers of physical and emotional care under the jurisdiction of medical staff, whilst the role of patients is to be seen and not heard.[27] Whilst the foregoing description may seem outdated and irrelevant in an age in which equal opportunities for men and women are enshrined within law and in which relationships between men and women have undergone a supposed sea change, it is arguable that the veneer of equality between the sexes serves to obscure the perpetuation of the Victorian gendered framework within which health care within the UK continues to be delivered.

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[27]As Atkinson and Delamont (1990:p90) point out, citing Sayers (1946), the need for women to be protected from work appears only to apply to that which is perceived by those in authority (predominantly men) to be interesting, high status, or highly remunerative.

It can be seen, then, that it would be naive and simplistic to assume that nursing staff within care settings have unlimited personal freedom in the organisation of their work and that the form and quality of care is dependent solely upon the individuals involved in its delivery. To hold such a view is to ignore the constraints upon choice which are contingent to nursing within the division of health care. What will, however, be the subject of further exploration are the very different responses which may be made by individuals operating within seemingly similar frameworks. I shall argue that, whilst symbolic interaction is explanatory of this variety of responses, importance requires to be accorded to the structural constraints which pertain and, indeed, it is the symbolic signification of these to different individuals which may determine the ranges of response available to them. For the individuals whom the students described within my study, the active creation of meaning which symbolic interactionists profess, was manifest in very different approaches to the delivery of client care and in the individual's subsequent re-interpretations and re-constructions of meaning.

The role of the individual: changing perceptions over time

In the final interview with students, immediately prior to completion of their three-year diploma programme, their perspective on the role of the individual had undergone some significant changes from the views expressed in their earlier interviews. As stated at the beginning of this section, in some of the students' earlier accounts the onus for the quality of care delivery was placed by them upon the individual nurse, irrespective of external forces. In the final interview, which took place following the students' 'management of care' placement during term twelve of the programme, their views on the extent to which one individual could influence events had undergone some revision. This altered perception appeared to be linked to the students' acquisition of experience and to their increased access to what Jane termed 'the wide picture'. Students were then in a position to understand that factors external to the individual could facilitate or impede the ability to provide optimum care.

It was also the case that, in earlier interviews, the students' perceptions of themselves was as extraneous beings within placement areas. This was not necessarily resultant from their supernumerary status, as they were frequently regarded as 'pairs of hands' and were relied upon (and expected) by staff to provide an active contribution to client care but was, rather, a consequence of

their transience. When students discussed the role of the individual, it was of others whom they spoke and not themselves. It may be that direct identification of themselves as being individuals responsible for care was absent due to their junior student status and consequent lack of knowledge and experience. This, in tandem with the temporary nature of their placement allocations, may have led to feelings of powerlessness and an inability to influence events, but it is nonetheless of interest that their assertion of the individual's accountability for the care provided did not extend fully to themselves, possibly because they had no difficulty in identifying the constraints that at times precluded their own ability to deliver the care that they considered necessary. By the time that they were interviewed at the end of their programme, students clearly identified the constraints within which the permanent staff members operated as being equally applicable to themselves.

So, it would appear that the students' altered perception emanated from acquisition of experience, from proximity to completion of their programme and from a realisation that considerations external to themselves were, in the near future, going to impact upon their own ability, as registered nurses, to deliver care to standards that they deemed satisfactory. Problems which had previously borne a relationship only in the abstract to their own future practice, now confronted them in reality. The altered perception also encapsulated the degree to which the students had become absorbed by the process of occupational socialisation and moved from a position of feeling in some senses removed from the ebb and flow of placement activity to becoming an integral and active participant within it.

The students did, however, make certain provisos, Jim suggesting that in some instances it was impossible to make any judgement at all upon the quality of care delivery. He cited as examples ward areas in which bed occupancy rates were quite frequently at a level of 140%. When this was the case, he felt it impossible to begin to talk about 'good' or 'bad' care, as crisis management was the only possible response (Interview 30:p 10). It would appear from Jim's comments that, if the organisation within which individuals work does not supply the resources necessary to ensure a satisfactory level of care, then, in his view, those employed within that setting cannot be deemed morally culpable for the 'care' provision.

Medical hegemony

Medical hegemony was a clearly emergent refrain, both explicitly and implicitly, within the students' accounts. For the most part, it was used to describe the devaluation of the nursing's staff's knowledge of the client, sometimes with the result, as in Euan's account (cited earlier within this chapter), of placing clients and staff at risk of physical and verbal abuse from clients.

Medical hegemony related to the core category of providing care in context, in that it was unable, or failed, to account for the contextual details about individual clients to which the nursing staff had greater access. This was due, in part, to the differing nature of nursing and medical work, the former involving sustained and often intimate contact with clients, whereas the latter usually involved encounters of an intermittent and fleeting nature and which were frequently accompanied by a ceremonial aura (for example, a ward round) which rendered intimacy unlikely. In some instances (which will be discussed in detail in the section on partnerships in care) medical staff considered themselves to be integral players, rather than leaders, of a multi-disciplinary care team, but this appeared to be the exception, rather than the rule.

One instance in which medical authority was challenged by nursing staff was described by Anne, following her term three placement in a mental health setting. A young woman, who had a past history of psychiatric hospitalisations in her home town in England, was admitted for treatment of similar problems whilst on holiday in Scotland with her husband and children. She was prescribed medication and, after a period of time, was deemed fit by medical staff to return home. On the morning of her intended discharge from the hospital, the nurse in charge, who was in her early twenties and had been qualified for two or three years, felt strongly that the client was in no fit state to travel.

> Anne:
> So, there were no doctors available, she couldn't contact them, so what she had to do was to ring the Mental Welfare Commission and, she had already interviewed the patient. She had made her own assessment and she rang the MWC and, I mean, she spoke to them for, it must have been nearly 15 minutes, putting a case for keeping this girl here, in the hospital, because there was no way that she felt that they could, you know, let her go. And I

think she was so articulate, and impassioned, in, in her pleas that what happened they, they allowed a Section[28] until the doctors could come and reassess her. And so she was stopped from going home. In virtually a couple of hours she was to leave. And she was reassessed and they decided to keep her in another week...And, you know, I thought it was marvellous. She was such a young nurse and to actually confront a very 'powerful' [Anne indicated quotation marks with her fingers], a very powerful body, but also to contradict what the doctors had actually said and to contradict their assessment. [pause] I think that was a very positive thing.

Dorothy:
So, can you say exactly what it was about that interaction that you thought was so positive, for you? From your perception of it?

Anne:
I, I think it was [pause] because this nurse recognised and had the background, the knowledge, and the skills to recognise that something was wrong and had the courage to try to do something about it. Despite the fact that, I mean she was kind of at the bottom of the heap. Well, except for student nurses [laughed]. And she was very young, fairly newly qualified, two or three years. And she was fronting up before, eh, the senior registrar and the MWC and I thought it took a lot of courage to do it. And I don't think that she was totally confident either because she was [Anne demonstrated slightly shaking hands] anxious. But, still she went ahead. And in the end it was successful. And it was obviously the right thing to do. And, and you wonder how the doctor made the assessment that he did.
(Interview 9:pp 8-9)

So although, as will be seen from other students' accounts (including a later experience of Anne's in a mental health day centre), there were placements in which all staff involved in client care worked in partnership and in which there appeared to be no conflicts in relation to occupational demarcation lines, these appeared to be the exception rather than the rule. Although the situation that Anne encountered was unlikely to be an everyday occurrence, it is interesting insofar as it highlights the enormity of the task faced by, and stress engendered for, nursing staff in any situation in which they felt that it was in a client's best interest for a medical decision to be challenged. It is also of interest that the stress experienced by the staff nurse, and the admiration which her actions aroused in the student, related to the challenging of medical staff and to negotiating with those in power (The Mental Welfare Commission). Whilst the nurse in charge had,

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[28]Compulsory detainment of an individual under a section of the Mental Health (Scotland) Act.

subsequently, to explain to the client that she was being compulsorily detained against her wishes, this was not the area identified as problematic or stressful.[29]

So, in the foregoing account, Anne explained what she perceived as constituting good care for a client. It involved a combination of theoretical knowledge and that which derived from sustained contact with the client including, in this instance, an awareness of the client's lack of insight into the severity of her condition. It was, thus, the ability of the nurse to place the client's care in the context of her specific set of circumstances, as opposed to adhering to a generalisable principle of accepting medical staff's decisions, that enabled her to exert influence in this situation.

The desired outcome required accordance of precedence to what the staff nurse perceived to be in the client's best interest, rather than to the patient's autonomy. It also involved over-riding the personal and occupational feelings of disquiet engendered by having to challenge medical dominance in order to achieve the client's best interest, although it seemed to be this latter aspect, rather than that of over-riding client autonomy, which created the greater anxiety for staff. (This may of course have been because the staff nurse felt that her proposed course of action was for the client's benefit and that the client's mental health problem meant that her ability to be autonomous was reduced.) The relationship between different occupational groups involved in direct client care will be further addressed in relation to partnerships in care.

It should be said at this point, however, that medical authority was seen by some students to have merit, in that it might serve to reassure anxious clients that someone, in a situation which to them was unknown and alarming, was in charge

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[29]Stein (1967) and Stein et al (1990) provide a much-cited description of 'the doctor-nurse game', a ritual in which experienced nursing staff demonstrate a respectful and deferential attitude towards medical staff, whilst concomitantly making tentatively-couched suggestions as to appropriate treatment for clients. This ritual serves the function of ensuring that the client's interests (as perceived by nursing staff) can be met, without the threat of a challenge to medical dominance. Clearly, for the staff nurse in the situation which Anne described, this ritual was an impossibility and, if one takes Stein's description on board, the overt challenge to medical dominance which was then necessitated was likely to increase her anxiety level, in its departure from 'normal' nurse-doctor interaction.

and knowledgeable. Jim highlighted this in his final interview (Interview 30:p7) and, indeed, said that he himself, in such a situation, might seek similar reassurance. Jim's opinion was that, whilst he considered the 'best' doctors to be those who communicated with, rather than to, clients, the latter held medical staff who were more distant in a higher regard. In this, his views were at variance with those of Euan, who commented that clients in his mental health placement preferred members of the medical staff who were less remote and who communicated well with them (Interview 24:p8)

Leadership issues: Who 'calls the shots' in nursing care delivery?

The emphasis placed by the students upon the importance of the charge nurse in adult placement areas is rather different from the descriptions of care provided by students in other branches of nursing, in which the role of the charge nurse appears, from their accounts, to be less clearly associated with power over subordinates. As I have no in-depth knowledge of the specific areas within which students were placed, identification of possible reasons for this are problematic. Nor is it the purpose of this study to explore the role of the charge nurse in a variety of care settings. Rather, the area of interest lies in the relationship between different styles of leadership and the students' perceptions of care. The charge nurse is the individual with overall accountability and responsibility for nursing care delivery within a specific area of practice. They thus have jurisdiction over the qualified and unqualified staff who deliver nursing care within that area, but the manner in which they exercise this, and the degree of success with which they achieve it, is variable. Students attributed this variety to a number of factors.

Within the health care settings described by students it was the case that first level registered nurses, with the exception of the charge nurse, changed posts with relative frequency, whereas second level registered nurses, care assistants and auxiliaries were much less likely to do so.[30] In the care settings described by students some of the latter groups of staff had been in post for twenty years or

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[30]In adult physical health settings the ratio of first level registered nurses (ie 'staff nurses') to second level registered nurses ('enrolled nurses') and care assistants/auxiliaries was higher than in the other areas in which students were placed.

more, often with little in the way of formalised staff development to facilitate updating of their practice.

The staff in Sheila's adult placement appeared to feel powerless to effect change in the charge nurse's management style and Sheila said:

> [that she did not]...know why they [staff] didn't get together maybe and, yeh, try and change things. I don't know really, you know. But certainly, from what they said, you know, they said things that you know, would indicate that they would do things very differently if they were in charge ..And all the nurses were quite young.
> (Interview 14:p 18)

This expressed desire for change, and seeming inability to achieve it, contrasted with the role of auxiliaries in some areas in ensuring the maintenance of the status quo against all comers. In these latter areas the unqualified staff and second level registered nurses had been in post for a considerably longer period (sometimes measurable in decades) than first level staff and, additionally, considerably outnumbered the latter. Whilst official authority in relation to care delivery was invested in first level staff, in practice it appeared to the student to rest firmly, for the most part, with auxiliaries.

Alan provided detail of the power that enrolled nurses and auxiliaries were able to exert over residents, students and newly-appointed first level staff in a care of the elderly setting.[31] The care provision was regimented, the residents being:

> . .sent off to bed at half six, seven at night, you know. There wasn't any, sort of, activity for them...In the mornings, it was just like a big rush to get through them all" [ie assisting residents with their personal care].
> (Interview 17:p 1)

In Alan's account, residents were sworn at when incontinent, verbally bullied to finish their meals and the staff appeared unwilling to spend time in sitting down

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[31]Clients were likely to be resident here for the remainder of their lives, being too frail to self-care, or to be cared for by their relatives or friends. This did not mean that the duration of their stay was necessarily short, some individuals being resident within continuing care areas for many years.

and speaking with them. When I asked Alan why he thought that the nursing assistants[32] carried out the care in the way that they did, he paused before saying:

> ...I don't know what it is. If it's that they've done it for so long, or [pause] they don't see each person as an individual, it's, it's [pause] just like an object, you know? It's just like a race to get everybody up...
> (Interview 17:pp 3-4)

Alan went on to describe an occasion on which a nursing assistant used a resident's shaving water to rinse his toothbrush and brush his teeth and another on which the rough and careless removal of uro-sheath tapes caused considerable resident distress. Alan brought these, and similar, incidents to the attention of the charge nurse, but although she listened to him and asked him to leave the matter with her, with an assurance that she would deal with it and that she was looking for the highest standard of care he concluded that, "...[paused and sighed] you could tell, she [pause] wasn't going to do anything, you know?"

Apart from disquiet in relation to the physical care, the placement area provided no psychosocial stimulation for residents, although they were clearly in no position to arrange this for themselves. No outings were organised, although a hospital bus was available for use and, although there were items for potential use in a reminiscence group, these were ignored.

'In with the bricks': de-contextualised 'care'

Alan felt that the root of the problem lay with the individuals concerned, some of whom had worked in the same ward for thirty years, and who reacted adversely to any suggestion of a change in practice. This was manifest in their attitude towards a newly-qualified male first level nurse who started work in the ward immediately prior to the end of Alan's placement.

> Alan:
> ...And he [the new nurse] was doing everything [pause] the care was really good, you know? He was taking his time with each patient and [pause]

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[32]Although this was the term that I used in asking him the question, the text of the interview makes clear that second level registered nurses were also involved in this treatment of residents.

Behind his back, all the nursing assistants were bitching about him, saying he was too slow and things like that. Just because they'd been used to, running the ward, getting everybody up, sort of thing, you know? And he's got a battle on his hands...
(Interview 17:p 3)

Alan added to the above, by saying that the new nurse would be unable to implement change and that, if he remained, it would be because he had adopted the approaches to care delivery of the care assistants. In addition to raising concerns with the charge nurse, Alan had made some tentative suggestions for changes in practice to the care assistants, but said that he was regarded as a 'daft wee laddie' and ignored.

I asked Alan whether he felt that the charge nurse was unable to effect change, or could have taken action and he replied that:

I think she could have done more, yeh. I think, I mean [pause] she definitely could have done more, she, I mean she was saying that the, she called them 'the girls', the girls were a great, good workers and things like that. Well, maybe they're getting through the work, but it, their standard of work's not up to much at all you know.
(Interview 17:p 5)

...and the student's response

That Alan raised the issue with the charge nurse demonstrated a change over time, as he had felt unable to voice the disquiet which he experienced in relation to care delivery in his mental health placement during term three.[33] As he said on that occasion:

...I felt bad...I felt awkward because I should have said something, but I didn't. You know? I think that's half the battle as well. You're afraid to speak up you know...you want to say something, but you have to bite your lip...in case I got a hard time...Bad assessment at the end, you know?
(Interview 6:p 9)

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[33]In this earlier placement the the standard of care was similar in many substantive respects to that in his care of the elderly placement. The area was one for continuing care for people who had mental health problems.

When I asked on that occasion how he had coped with the feelings which this engendered, he said that he:

> ...just switched off [pause]. It's just, I just had to get on with it. [pause] I felt I should have said something, but if it was going to backfire on me I was just going to keep quiet. [pause] But, now [ie meaning in future placements] I think I will speak up...
> (Interview 6:p 19)

When we spoke on the occasion of the third interview, Alan said that he no longer experienced speaking out as problematic (Interview 17:p 12), although he did feel that verbal indication of his concerns was insufficient, as the charge nurse in his care of the elderly placement had not, so far as he was aware, taken any action following his discussion with her. He identified that in future he would, additionally, commit any concerns to paper, as he felt that this would necessitate some form of official acknowledgement.

Alan attributed his willingness to speak out to having attained good assessments to date and, as a result, experiencing less concern than previously at the possibility of receiving one which was adverse. He said that he would feel more at ease in relation to speaking with university staff about concerns and, additionally, said that:

> ...I don't know if it's, a feeling, I've had enough...bad practice and you think, 'Why should people be taking this?' You know? I mean, if that was me [pause] lying in that bed, getting that standard of care, I wouldn't be happy so [pause] I mean, that's the way I view it, you know...you try to get things improved, you know [pause] coz, I know if I was in charge of that ward, I'd want to get the highest standard of care...
> (Interview 17:p 13)

In this area, then, the relationship of the charge nurse to those whose approach to care she could ostensibly control was very different from that of the charge nurse in Sheila's adult physical health placement. One possible explanation, suggested earlier, was the predominance of unqualified to qualified staff in the area that Alan described. Another was that the unqualified staff had a greater length of experience than the charge nurse and were her senior in years. These factors alone, however, are insufficient as an explanation, as in other areas in which similar comments could be made they did not result in the poor quality of care that the patients received in Alan's placements.

It can be seen from both Sheila's and Alan's accounts that the leadership style of the charge nurse impacted upon care and upon the students' perceptions. Although, in each account, the negative image was attributable to different substantive factors, there are nonetheless underpinning similarities, in that both charge nurses appeared to avoid engagement in potentially confrontational dialogue with staff. Whilst the charge nurse in Sheila's ward achieved this by refusing to allow any questioning of her directives, Alan's charge nurse did so by failing to confront areas of poor care delivery by staff. It can be seen that, although the charge nurse has the theoretical ability to set care standards, the translation of this into practice may be problematic. The interviews at which these accounts were provided took place at an early stage within the students' programme and the charge nurses' failure to provide care to a standard that the students considered acceptable was attributed by them to the personal qualities of the protagonist, rather than to organisational constraints.

Alan compared his placement ward with another continuing care area for elderly people which he had visited within the same hospital. In this unit the atmosphere appeared to be very different, a fact that Alan attributed to the influence of the charge nurse. The decor was brighter than in his own ward and the charge nurse had arranged for the installation of cable TV to enable residents to watch original episodes of old programmes, which they enjoyed. In this ward residents could:

> ...go to their bed when they wanted, get up...if somebody sleeps during the day, gets up during the night, well, that's fine...It was just totally different. (Interview 17:p 5).

So here, within the same hospital, and in wards which presumably had similar access to funding, Alan witnessed contrasting approaches to the long term care of elderly people. Interestingly, the charge nurse had commented to Alan that he did not have problems in attracting, and retaining, qualified staff and that there had "...been no back injuries here and things like that". I did not query what might be meant by this comment, as it presumably referred to a lower level of staff absence through illness than in other wards, although one can speculate as to whether this was resultant from an emphasis on efficient moving and handling of patients, or to rather more subtle influences. Whilst it has to be borne in mind that Alan's description here was of a placement of which he had no first-hand experience, it is

nonetheless of interest in his highlighting of points that he considered would make for delivery of good quality care.

In the fourth interview, Alan spoke once again of the depersonalisation of care which he had witnessed, on this occasion at the state hospital. This had come under the jurisidiction of the NHS approximately six years previously, prior to which it constituted part of the prison service. Many individuals working at the state hospital during Alan's placement had been employed for many years and the custodial ethos, in Alan's view, remained extant. There was a shortage of local employment opportunities and Alan said that quite a number of staff worked at the state hospital through lack of alternatives, rather than through a desire, or ability, to care for residents. Although he had been told that many changes had occured and that anyone who had left prior to the changeover would no longer recognise it, his own perception was that it took more than a formal change of status to alter the underlying culture. Alan felt that a lot of the problems were resultant from management neglect of both staff and residents. Very few of the qualified staff were first level registered nurses in the field of learning disability, despite the number of residents who had such needs. Some of the staff, both those who were without qualifications, and those who were second level registered nurses, had received little in the way of preparation for practice, or continuing education, throughout their period of service, but were now increasingly under pressure to undertake courses in order to obtain formal qualifications.

It is of interest that Alan, who had by this point gained confidence in vocalising concerns when he encountered what he considered to be bad practice, felt, after initial attempts to do so, that it was a pointless exercise because:

> Alan:
> ...the guys [staff] that had been there twenty, thirty, years...weren't happy at the younger people coming in and the different approach, you know...you were just laughed at, you know? It was [pause] so demoralising...after six weeks I was feeling burnt-out, you know? It was just stress at knowing that there's so much potential, so much could be done here, it just wasn't being done...I was glad to get out of there...As I say, before, if I had seen bad practice, I *would* eh, try to make recommendations, or say, "Maybe do it this way?, or things like that, but there you just couldn't. You know. It was just all, so [pause] Yeh, you just got a sense of hopelessness, you know? That nobody was taking on your ideas, you know and [pause] you were just

fighting a losing battle and you were burning yourself out trying to do anything..
(Interview 26: pp 1-2,p 3,pp 6-7)

It can be seen that Alan, who in early placements had felt inhibited about speaking out about what he perceived to be bad practice for fear of reprisal, had moved by the time of the second and third interviews to being able to vocalise concerns. This ability to 'speak out' was attributed by him to three factors. One was that he had received good clinical assessments and another was that he felt that he now knew the university lecturers and related well to them. The third factor was that he had surfeited on witnessing what he perceived as bad practice and felt that he could no longer reconcile silence with his conscience. He was therefore prepared to take the risk of making himself unpopular and receiving a poor assessment as a consequence. (It is of interest to note that, even although he had spoken out on several occasions, his clinical assessments had not suffered as a result, nor had he encountered hostility within placement areas.) In the final interview however, Alan identified that he failed to voice concerns due to a sense of the futility in doing so. His remarks within this interview suggested that this may have been due to the factors specific to this placement but, equally, it could have been a cumulative process. In the past, when he had spoken out, both to placement and university staff, it was clear that no action had been taken as a result and this knowledge may have contributed to his decision not to actively pursue his concerns about the care delivery. This theme of sympathetic listening by staff to the students' concerns, followed by a void, was one which was common in the students' experience.

'In with the bricks': care in context

In contrast to Alan's experience, Jim, speaking about a continuing care unit for people who had severe learning difficulties and physical handicap, described the care, which was given in the main by unqualified staff, as "...very, very good. I think probably the best I've seen. But it's very regimented." (Interview 15:p 11). When I asked what made the care the best he had seen, he said that it was because a lot of thought went into it. The unit was self-contained with responsibility devolved to staff for the care of specific residents. In addition to providing assistance in all aspects of their physical care, the standard of which Jim felt was very high, staff responsibilities extended to ensuring that residents had supplies of

soap and clothing. Jim considered that, for the staff, "...it was just like they were looking after their kids, in a way, you know. I thought that was very good. They were very intimate with the, with the, the patients" (Interview 15:p 11).

When I queried in what ways the regimentation had been manifest, he cited the existence of a book which stipulated the days on which each resident was to receive an enema. He then qualified his remark by saying that at least it ensured that no residents suffered from constipation and he continued his verbal reflection on his use of the term, concluding that perhaps the care was not really regimented.

As Jim had, within the same interview, expressed a generalised criticism of nursing assistants, saying that many appeared to lack motivation and to demonstrate a very rigid and regimented approach (Interview 15:p 3,p 11), I asked if he could identify what made the difference in the learning disability placement. He replied that it was:

> The individuals involved I think. They're just really nice people...some of them did smoke, but they weren't, the ward routine wasn't run on who's getting the next [pause] [D: fag break?] Yeh. The ward sister was very good. I think she made a big difference because she was a real tartar. You just didn't cross her at all...she's very good at what she does. I think everyone else, sort of, follows along. A benign dictator, she was. She was very good...A lot of the staff were actually genuinely frightened of her...
> (Interview 15:pp 12-13)

In relation to the care assistants, he said that:

> ...I think they looked upon them [residents] as being their children, their surrogate children more or less, I think that was the attitude. I was very impressed with it, very impressed. It was really genuine...more like a family thing than a caring situation[34]...So it shows it's the individual really maybe. You could draw that conclusion. And also the setting it's in, I think.
> (Interview 15:p 13)

There are many points of interest in Jim's narrative, not least the contradictory nature of some of his comments. In Jim's placement some of the features of the organisational framework and client group were very similar to those within Alan's mental health and care of the elderly placements, in that unqualified staff

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[34]It is of interest to note that a differentiation was made here between the concept of 'family' and that of 'caring'.

constituted the major part of the workforce and had been in post for many years. Clearly, however, the charge nurse in Jim's placement was a much more dominant force than in the placements described by Alan. The client groups in each placement were similar, in that they comprised people who were physically and mentally unable to self-care and required to be cared for, on a long-term basis, within an institutional setting. Few of the residents received regular, frequent visitors and they lacked the ability to express any concerns, either formally or informally, in relation to the quality of the care that they received. They can be seen, in this respect, as constituting particularly vulnerable members of society, being totally dependent upon their carers for their physical and psychosocial wellbeing.

The status of different client groups

In some instances, as can be seen from the preceding extracts, the vulnerability of clients was not abused and they were treated as human beings whose identity as individuals was acknowledged and accorded credence, whereas in other settings this was clearly not the case and clients were, in Alan's words, treated as objects. As the approach adopted had clear implications for the care provision and the students' perception of this, it is of importance to explore possible reasons for the differences.

The care of people who are physically and mentally vulnerable and dependent may generate problems for their carers. It has been suggested (Menzies 1960) that these may take the form of anxiety generation and feelings of helplessness in the face of suffering, which the carer may attempt to control by means of distancing themselves physically and/or psychologically from those for whom they care. It is, then, possible that this was a reason for the failure by staff in Alan's placement to treat the clients as individuals. One method of physical distancing may involve the use of a task-orientated approach to care delivery, in which client care is fragmented into a series of discrete tasks, for example bathing, dressing, making observations of temperature, pulse and blood pressure, dispensing of medication. This has the effect of reducing the amount of time spent by any one nurse with any one client and may ameliorate the stress engendered by sustained contact and its contingent possibility, or probability, of emotional attachment and attendant vulnerability for both the carer and the person cared for. Physical and emotional intimacy, and the toll which this may extract, is usually considered by society to lie

within the realm of private, as opposed to public, interaction. For a paid carer to adopt a role as 'significant other' vis a vis a patient/client, may entail an unacceptable emotional risk.

Individuals who are elderly and are physically and mentally frail, may also create anxiety by virtue of identification. Carers may be able to accommodate care of people who have learning difficulties more readily within psychological schema, either because these clients possess what are perceived as child-like qualities, or because they are not perceived as being as the carer is, or is likely to become. The same cannot be said of elderly people, who may provide for the carer a vision of their own future. One response to this may be to care for the client in a way which the carer would find acceptable were it provided for them; an alternative strategy may be to ensure a psychological distancing from those for whom they provide care. This may extend to the objectification of clients described by Alan.

Complementary to the above, is the argument that caring per se is devalued within our society, in that it is seen as being something which can be carried out with minimal, or no, specific preparation for practice, as it lacks a concrete skill base, and is traditionally associated with work carried out by women, frequently in the absence of financial remuneration or public acknowledgement (Graham 1983, Colliere 1986, Ungerson 1987, Hugman 1991, Davies 1995a, 1995b). When people care for those who are not accorded a high status within our society, for example those who are frail and elderly, those who have a mental health problem or a learning disability, then the feeling experienced by the carer of being devalued may be compounded.

In this reading, a focus on task orientation within nursing may be less an anxiety-reduction mechanism but, rather, a quest for identification of the specific and the readily-recognisable, which the more nebulous concept of 'caring' may lack. Technological and intensive care tends to be attributed with value and status, in the eyes of many nursing and medical staff and within society at large. The technological complexity of care tasks is likely to increase in tandem with the acuteness of the client's health care deficit, the skills of nurses within intensive care units being seen as technologically superior to those faced by someone caring, with minimal equipment, for a frail elderly person. Thus, within the occupation of nursing, some manifestations of 'nursing care' may be accorded higher status than others. That it is possible for most people to survive for a

reasonable lifespan in the absence of medical technology does not reduce but, rather, may enhance, its esoteric 'glamour', a fact which underpins the popularity of television programmes in which the action occurs within acute care settings and seldom, if ever, within continuing care units. Identification in the public view of nursing as comprising high drama, ethical dilemmas and either cure, or death after heroic nursing and medical intervention, is self-perpetuating and indeed formed part of the recruitment rhetoric published by the Department of Health (England and Wales) during 1998. It is of little wonder, then, that nurses who work within long term care settings, caring for groups of people who are themselves devalued by society, may experience problems in relation to their self-esteem.

In the face of this organisational neglect there are a variety of ways in which efforts may be made by staff to reduce the level of their disquiet to manageable levels. For the care assistants described by Jim in the learning disability unit the sustained and intimate contact between clients and staff resulted in clients being accorded individual status and emotional investment by staff. This appeared to be the process at work in Jim's descriptions of the carers treating the clients as though they were their children. It did not involve, note, treating the client as their equal in status[35], although it did appear to have a positive outcome in relation to care provision. There may also be links here with the charge nurse in George's adult physical health placement, described earlier, who spoke of '*my* patients'. If a carer can perceive those for whom they provide care as belonging to them, in some sense, then they may invest greater effort into ensuring that they provide good care.

An alternative form that coping may take appeared to be that adopted by the carers within Alan's care of the elderly placement, in which the clients were treated as objects rather than as people. Rather than being viewed as individuals who required assistance with activities of living, clients were de-personalised and seen as work items or units, to be processed as rapidly as possible, despite the fact that, within this area, there was no requirement, organisational or otherwise, to complete the clients' physical care within a specified time frame.

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[35]ie, although Jim referred to clients as being regarded by staff as their children, it was quite frequently the case that the clients were adults.

Alan, in his final interview, in discussion of his placement at the state hospital, spoke of a similar form of depersonalisation. He used the contrast between the 'on-ward' care, which was custodial in nature and aimed at containment, with that which was 'off-ward', ie the clients moved from the ward during the day to an education unit, the aim of which was therapeutic and included activities such as arts, crafts and sports. Whilst staff in the latter demonstrated a positive and individualised approach to the clients, the staff in the ward areas appeared to make active efforts to depersonalise and demean clients and to distance themselves from any emotional involvement. Alan described the differences as follows:

> Alan:
> ...in the Educational Unit, it was brilliant, the motivation that these nurses put in and, and just the care, you know? And *really* interested in the clients, you know? And you could see that as well, with patients, you could see they got a lift when they went up to these places and they could see that people were interested in them and - taking time with them and that. Soon as they went back onto the ward, you know, they were just knocked and mocked and that's [pause] It was like two different places, you know? Em. Even when I was on-ward, em [pause] I was, I spent a lot of time trying to *know* the patients, you know, just chatting away and, you could see certain staff members would frown on this, you know?...I was trying to strike up relationships with them [patients] and, just being *human*, you know? And there was one occasion, I was talking away to a patient, em, just about his interest and sports and things like that...and the nurse says, em, "Alan's not interested in you, talking away to him about this, you know. He's just being polite". [student laughed, but incredulous, not amused]...And this guy's face just dropped...
> (Interview 26:p 3)

The significance of the foregoing discussion is that, whatever the psychological and sociological reasons for objectification of individuals who require care, the result was that the patient was *decontextualised* from factors that rendered them unique. Providing care in context was, then, precluded. As this emerged as the core category and basic social process used by the students within my study in their determination of care quality, it is unsurprising that its removal from the scene caused them disquiet.

Getting through 'the work'

Another organisational constraint which contributed, in the student's view, to depersonalisation of care, with a consequent failure to perceive the client 'in context' was allocation of inadequate numbers of staff to meet the clients' needs. When I asked Jane, for example, why she thought that the staff in her care of the elderly placement became settled into a particular routine, she replied that:

> ...I think it's a way of getting through the day because, bar one person, as I said, everybody needed some amount, somebody there to do physical care...the staffing level was just the same as it would be in a ward that would have, maybe twenty folk, self-care. And you've still got the same number of staff. It was [pause] just a way of getting through the shift.[36]
> (Interview 18:p 9)

Furthermore, she suggested that a form of 'macho' culture underpinned some of the care assistants' efforts, including a devaluation of assistance provided by 'outsiders'. For example, Jane explained that the inadequate numbers of staff necessitated a reliance upon the frequent employment of agency staff[37], but that these individuals were denigrated by ward staff due to their failure to match the degree of speed that the permanent staff possessed. Jane said that it did not matter that the agency staff:

> ...sat and chatted and found out the way that the, you know, they [patients] normally got up, 'Do you want to try and do it yourself?' There was none of this, none of this promoting independence [on the part of the permanent staff] by getting the person to do it. It was a case of, 'I'll whizz the buttons up quicker coz that means I can get to the next person quicker and then my bay'll[38] be done quicker. And, one, it'll look good because I can offer help

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[36]That the ward was so short-staffed, and that those who worked there had then to devise survival strategies, links again with the comments by Davies [1992] in relation to 'coping management'. That Jane described the staffing levels as comparable to those within areas in which many clients were self-caring, or required minimal assistance, provided another indication of the way in which some areas within health care, such as care of the elderly, are accorded a lower priority than others in terms of resource allocation.

[37]Jane did not identify whether employment of agency staff was necessitated by staff absence due to illness, recruitment difficulties, or to being regarded by management as cost effective (ie precluding the need for contractual responsibility).

[38]Client care areas were arranged in 'bays' within the unit, each providing the

to somebody else, coz I'm so efficient I'm finished, or [pause], or, or I can get on with cleaning my lockers, so that I can go for a fly fag break.'
(Interview 18:p 9)

A similar theme appeared to underpin the image maintained within the ward areas of the state hospital, although its manifestation differed. The behaviour of some of the clients could be unpredictable, but Alan felt that there was a lack of understanding on the part of the staff of the needs of people who have learning difficulties (many had received no specialist preparation for practice in this area). The atmosphere which prevailed was:

Alan:
...like an army boot camp...lots of swearing and barking orders and things like, you know...on-ward there was hardly any nursing, I would say. It was more prison-orientated, you know. Containment...It was just a power trip for all these nurses, you know?
[however]
...A big thing I noticed was, staff weren't supported. Eh, I think there was a few people had personal problems there, that weren't being supported by staff, you know? There wasn't any clinical supervision, or, it was, there was no support mechanisms, if things went wrong, that people could be picked up, or...alleviate their stress, or whatever. They just had to get on with it, you know? A sort of macho sort of image, you can cope...it's staffing levels as well, I think. They need higher staff, more staff on the wards, you know? There's twenty-six patients on that ward and, eh, two, maybe a staff nurse at times, maybe two enrolled nurses, maybe a nursing assistant. You couldn't do much, you know?

Dorothy:
So, did you feel maybe the staff behaved like that because they felt that having a high degree of control was the only way they could cope with it?

Alan:
Yeh, yeh. I think they had to have this [pause] power, this feeling of control, you know? But I think they could [indistinct]...why did there have to be a twenty-six bedded unit, why couldn't there be six-bedded units, you know? But, again, it was money and staffing...
(Interview 26:pp 1-5)

This description of care staff being overworked, battling against the odds to complete their work unaided, but sometimes, for example in Jane's ward,

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sleeping, and to some extent living, accommodation for 4-6 patients.

seemingly resentful of assistance when it was proferred, was a recurrent theme within the students' accounts and was most commonly identified as occurring within care of the elderly and learning disability placements. In acute care areas the arrival of additional staff tended to be viewed by the permanent staff in a more positive light.[39]

It was not, however, the case that the focus upon individualised care was any greater, within acute care areas, than that upon tasks. Jane identified that, in instances in which staff felt perhaps helpless in the light of deterioration, or lack of improvement, in a client's condition, they focused upon the physical, observable and quantifiable aspects of care. In relation to the highly visible example of wound care, she commented that:

> ...that makes the staff nurse feel good because they've done the wound dressing but, at the end of the day...it's usually the fact that they're [ie the client] sitting there, feeling miserable because they've been in hospital for five weeks...they've got this dressing on their foot, that's not healing, but you're not really dealing with that part of it...and they [ie the staff] weren't dealing with that side of things, it was just, "Oh well, the wound's looking better today then".
> (Interview 27:p 11)

So, here, in the accomplishment of tasks, the formal acknowledgement of the client as an individual was over-ridden by the focus upon one aspect of their identity and a there was a concomitant failure to engage with the other areas in which 'success' was less readily achievable.

A similar focus upon task accomplishment, which took the form of implementing care for a client who would have been able to carry this out unaided, if given sufficient time, was also discussed by Jane:

> ...it's something that I don't think is *bad* practice, as in any malice, em [pause] but there was a nursing assistant, em. I'd left shaving materials for a gentleman who was quite able to shave himself. [pause] It was a general medical ward and he had a left-sided weakness, but he was quite able, you know, to shave himself, but instead this nursing assistant had just come along and pulled the curtains...And she was in there, almost ready to start shaving

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[39]There may be a link here with the image of acute care being associated with cure and reinforcements thus being regarded as an acceptable response to a crisis.

him and I had said to her, "Excuse me, you know, Mr So-and-So'll be able to shave himself. Can you, you know, sort of leave him?" [pause] Em. [pause] And I went away and then, five minutes later, went back...and she was shaving him again. She obviously felt she needed a job to do and it was her job to do it, so [pause] It's not bad practice but, really, you're taking away that individual's independence, so in the end it could have a bad result. (Interview 27:p 5)

So, here, the nursing assistant considered that she had been employed to implement client care and she was determined to do so, regardless of the requirements of the individual. That the client might, if left to his own devices, have shaved slowly, or inadequately, might have been viewed by the nursing assistant's co-workers as an indication that she was not fulfilling her role as competently, or as quickly, as the ward ethos demanded. It is also of interest that Jane did not identify this as 'bad practice' due to the lack of malice by the perpetrator. It would appear, then, that intent played a significant role in her designation of moral praise or blame.

As James (1986, 1992a, 1992b) has pointed out, physical tasks may be successfully completed as discrete entities, with relatively little emotional input on the part of the carer, whereas emotional care is exhausting and infinite. It is important to note that neither Jane, nor any of the other students, denigrated the physical aspects of client care in favour of the psychosocial, but they considered that the focus upon the former was at times accorded undue importance, rather than being seen as one component of a total package of care delivery. At times this focus was perceived as being resultant from short-staffing but, more frequently, was attributed to 're-arranging deckchairs' as a substitute for engaging in the wider, and more complex, issues. The fragmentation which resulted from this decontextualisation of care was seen by students to lead to a decrease in care quality.

Short-staffing was also one factor which led to depersonalisation of care during several of Anne's placements. In relation to this, she made the following comments:

Anne:
...I know sometimes in mental health, there's a tendency to [pause] see someone as [pause] "the manic", on the ward. "Oh, we've got three manics

on the ward just now", which really [pause] objectifies people. Em, it, all right, they do have a manic illness, but if you look at them individually and what the illness means for this person, you know? Um, it can mean, sort of marital problems, em, you know, work problems for somebody else, em [pause] and I, I think you do need to take the whole picture, which is not always done...

Dorothy:
What do you think maybe stops people, seeing people in that more holistic way? [pause] What makes them say, "We've got three manics in the ward"? Rather than?

Anne:
Perhaps pressure, you know. There are a lot of things to do. There are lots, of paperwork, you've maybe got a ward round coming up, you've got, you know, two people being discharged and you're trying to do all these things, em and also [pause] deal with, sort of ongoing problems that other people might have. So, I suppose, I suppose pressure. Em [pause] perhaps not seeing people - you know, that something extra I was talking about? Perhaps, perhaps not being aware of people as people. Not being able to see that far, you know? Or, or seeing it as just a job. You know?...
(Interview 29:pp 4-5)

Some of the comments made in the foregoing are seen as being attributes of the individual, for example the ability, or lack of it, to view clients as individuals. However, the other reasons cited, ie the paperwork, the administrative work, the ward round, are all factors engendered by organisational requirements. Once again, as in Sheila's description of the charge nurse in her adult care placement, there is the impression that the organisational framework, rather than functioning in order to facilitate care delivery, may at times impede this and create an atmosphere in which the clients' presence is seen to interfere with the smooth running of the bureaucracy, rather than constituting its raison d'etre. The effects of the organisation upon care will be discussed in detail in a later section within this chapter.

An earlier example of depersonalisation had occurred during Anne's placement with people who had learning difficulties. She was working within the day centre, but staff were sometimes sent from there to wards to provide assistance at clients' mealtimes. Anne's explanation of the problems which this caused were cited earlier (within Chapter Three) and were resultant from the staff's inability to see the client in context. Reduction of the clients to the status of objects that required

attention, created depersonalisation of care to the extent that Anne found it difficult to see past the task to the person for whom it was being carried out. The clients whom she cited were individuals whose degree of learning disability and physical incapacity rendered it impossible to develop an instant rapport, as reciprocation from the client as a response to care appeared to be absent. There is perhaps a link here with Noddings' (1984) assertion that reciprocity is a prerequisite for care. Whilst I was critical of her stance in the literature review, and deemed many of her concepts inappropriate in relation to nursing work, it is perhaps of interest to note their potential relevance here. Clients who are unable to reciprocate are perhaps at risk of carers being unable to form an affective and effective link, although provision of physical care may be of an adequate standard.

A further example of the manner in which clients were depersonalised and their needs devalued or negated related to the restriction within some of the students' placements of clients' freedom to access toilet facilities. Clients in the care of the elderly placement described by Jane were unable, with the exception of one person, to walk without assistance. 'Toilet rounds' took place at certain times and requests made by clients outwith these (or a disinclination to make use of toilet facilities when these were offered) were usually met by staff disapproval, either verbal or non-verbal, and, in some cases, refusal. It is arguable that, unless psychological distance from clients was achieved, and maintained, such a refusal would be unsustainable or, at the very least, cause psychological discomfort to staff. It is only by viewing clients as 'other', with a concomitant refusal to entertain the possibility of oneself, or someone for whom one cares, being in a similar position, that such treatment is unproblematic.

Jane described one client who requested to be taken to the toilet frequently, but on most occasions did not void urine. The staff used this as their rationale for refusal to assist this person to the lavatory on request and Jane appeared to view this as possibly acceptable, due to her own lack of specialised knowledge of the client's condition. It is of interest that possible reasons for the requests made by that client (or by others) to visit the lavatory in the (perceived) absence of a physiological requirement to do so appeared to be unacknowledged by staff. There are links here also with the unswerving adherence of the charge nurse in Sheila's ward to 'routine' and disregard of what she appeared to perceive as the patients' attempts to thwart this.

From the foregoing, it may be seen that students viewed depersonalisation of the client as evidence of poor quality care and the psychological distancing which was a prerequisite for its delivery was regarded by them in a negative light. This has clear links with the core category of providing contextualised care; its decontextualisation here resulted in clients being viewed as a series of tasks to be completed, rather than as individuals. Conversely, care which demonstrated engagement with the client as an individual was praised as being evidence of good practice. This perspective did not change over time. It may of course be argued that the focus upon individualised care as being desirable was a reflection of the socialisation process that students underwent within the university setting and from other theoretical sources, possibly in conjunction with their identification of myself as a part of that framework and that it thus constituted a 'pleasing' strategy or tactic. Whilst this cannot be discounted, running counter to it were many occasions on which comments made were clearly not of this nature.

There were also, however, many examples of situations in which active attempts had been made by staff to individualise care. One such was cited by Alan. It has been policy during recent years to re-locate people with learning difficulties, previously resident in institutional settings (an estimated 10% of the total number of people who have learning difficulties) into community settings. Many of the residents (and staff) had been located within institutions for many years and students described the different ways in which this move was handled, most of which facilitated and some of which inhibited, a positive experience for the residents and for their carers. Alan described one way in which residents who had moved to a new setting were individualised in the eyes of their new carers. (These residents had learning difficulties which were sufficiently severe to preclude instant communication or reciprocity with those with whom they had contact.) 'Life story books' were prepared by carers within the institutional care settings and taken with individual residents in their move to their new community home. These books provided the new carers with a picture (literally, in the form of photographs taken over the years, and in writing) of the resident as an individual and enabled them to be set in context, the theme identified by the students as being of central importance in the delivery of optimum care. As Alan described its role:

> Alan:
> ...to give the new carers a sort of an identity [ie of the resident], rather than just careplans, saying, "These people have problems with this, this and that"...

Dorothy:
Yeh. It maybe helps the carer to see the person as an individual [indistinct, both talking]

Alan:
Yeh, rather than somebody with epilepsy, or cerebral palsy, or all the mobility problems, or things like that. You're seeing the character, you know. I think that makes it easier for the carer to know the person, rather than taking months or years to know them, you know?
(Interview 26:p 9)

Partnerships in care

The foregoing section discussed the role that individuals play in care delivery. One theme which emerged from the data, and achieved particular prominence subsequent to the students' community placements within their branch programme, was that care quality appeared, in the students' perception, to be higher when those responsible for its delivery worked together as a team, included the client as an active member of the team and adopted an inter-dependent, as opposed to independent, occupational approach. Once again, this related to the core category, in which contextualised care emerged as the central and stable factor which facilitated good practice and to which all the other categories related.

The recommendations of the *Acute Services Review* (Scottish Office Department of Health 1998) prioritised the development of managed clinical networks, the stated purpose of which was to maximise resources in order to deliver integrated, high quality client care. In order to achieve this, the *Review* recommended a close examination and redefinition of traditional inter-occupational boundaries and identified the managed clinical networks as a means of promoting new and effective ways of working, for example, in extension of existing staff roles and multi-disciplinary team working.

The issues raised by the students, which subsumed the theme of partnership, related to the care setting, the power, status and accountability of the different occupational groups that comprised the multi-disciplinary team and the effect of these upon both the providers and recipients of health care. The focus of the occupational groups differed, individual client autonomy, for example, being

generally accorded higher status (in the students' view) by social workers than by nurses. The nature of the contact between care providers and recipients also varied, that of nurses being generally perceived as more sustained and intimate in nature than that of medical staff, the latter's interactions with clients being seen, for the most part, as intermittent, fleeting and accompanied by greater ceremony.

Whilst a clear definition of the nurse's role, including the notion of occupational autonomy, was, in general, positively perceived by students, it was nonetheless viewed as desirable that the different occupational groups involved in health care delivery worked together as a team, in order to provide the integrated approach that students saw as necessary for the provision of contextualised care.

Partnerships were considered by the students to be effective when the importance of the client as a partner was acknowledged, in reality, rather than as mere rhetoric. The centrality of the client's involvement was identified earlier, in relation to the effect that community settings had in ameliorating the power imbalance between client and carer. It was also specifically identified by its absence in some instances within institutional settings. George however, discussed the client as a partner in care when speaking of primary nursing within a hospital setting. He had also identified that, in his own practice, he now carried out care *with* the client, rather than *for* them.

> George:
> ...you have to...go with the person that you're looking after. And, and say to them, look, you know, it's you, it's your time [pause] you know, "Let's build a picture of what you want to do. And work from there." Em [pause] I think that's something that, since I worked in that ward in [hospital], that was kind of the first placement in branch I think [pause] eh [pause] I think [pause] that was the first time I'd come across, like, primary nursing. So, I think, the whole issue of partnership came to be important because of primary nursing and that that's why I, em, the nurse and the patient come together closer. (Interview 28:p 2)

It is, however, of interest that this partnership between nurse and client was individualised and was less likely to develop if a team, rather than primary, nursing approach was utilised.

George:
Whereas, in [pause] in a team [pause] you kind of become disjointed, or, or you can do if, if the team is constantly changing. If there's no kind of set pattern, em, the patient doesn't know who's looking after them. And therefore loses this partnership, whereas with the primary nurse, ok, the nurse isn't there twenty-four hours a day, but they know what their nurse is doing, their primary nurse has usually written in their careplan and can say and can write down the detail and say, and there's one person they can get back to, whereas in a team, often it might be a different person who starts the careplan and who finishes it because it's all the 'green team's' careplan. And so, it can become quite disjointed, care...And I think that this, this aspect of, of primary nursing, looking after, say four people, for four full days [pause] adds to the continuity of the relationship, this partnership...
(Interview 28:p 3)

So, in the foregoing, George linked the concept of nurse/client partnerships with that of primary nursing. Although this was an example from within an institutional setting, it is of interest that the substantive elements that facilitated the development of a partnership in this instance were those which obtained within community settings, ie the one-to-one relationship between client and nurse and the concomitant sustained responsibility and accountability of the latter for care of the former. It is arguable, then, that it is the manner in which nursing work is organised, irrespective of the actual location in which care provision occurs, that facilitates or inhibits development of one-to-one relationships and consequent partnerships between client and nurse.

Anne's community placement within a day hospital for people who had mental health problems, was similarly identified, in her third interview, as being one in which the clients were actively included as partners in their care. Clients were asked to complete user-evaluation forms, on which they could identify whether they considered that their care requirements were being satisfactorily met and what elements could be included, altered or omitted, in order to improve their care provision.[40] In my subsequent interview with Anne, I reminded her of this and asked if she had encountered similar partnerships with clients in her later placements, which had been within institutional settings:

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[40]The extent to which the findings of the user-evaluation forms were implemented is unknown. The point here, however, is that Anne identified their use as being a positive example of active client participation in care and of nurse/client partnerships.

Anne:

...certainly there's not, there's not so much emphasis on [pause] giving patients choice. And things are done in a certain way [pause] and things are beginning to be provided like, you know, occupational therapy. There seems to be a bit more input [pause] there, so patients do have a choice about maybe going to a relaxation group, or going to an art therapy group or something. But, it's not really what *patients* want. Patients look for, other things. And the thing that *every* single patient that I've *ever* met in any hospital has said is, "It's *so* boring!"...not everybody wants to do relaxation and that seems to be, you know, the number one thing on the wards...and, as far as careplanning and that goes, there's certainly no [pause] sitting down with a patient and saying, "Well, you know, what do *you* think?" You know? "What do *you* see as your main problems? How can we help that? Well, what would you like me to write in the careplan?" You know? Um [pause] this is what we're taught. We're taught that it should be, you know, a two-way thing, eh, but I've never found it to be. There's not one place that I've been that I've found it to be a two-way thing, where, you know, the patient does have a sense of control there.

(Interview 29:pp 7-8)

So, in the foregoing, whilst Anne had encountered one area in her programme in which the client was actively consulted as a care user, this was the exception and not the rule. The official rhetoric, within the university setting, and in all probability within the hospital trusts' philosophies, is upon the client being involved in decision-making, but this was not borne out within the reality of everyday practice. Anne perceived that it would be beneficial and that clients themselves identified that the current care provision was insufficient to alleviate the boredom attendant on being within an institutional setting, but she felt powerless to change the system.

Once again, this illustrates that, although to some extent care provision is determined by the individuals concerned, as an interactionist theoretical perspective would propose, the individual was only free to operate within the constraints imposed by the organisational framework. It may, of course, be argued that different individuals react differently within any setting and that some may be able to change the status quo even in the face of adversity. However, it would appear that some organisational frameworks inhibit, and some facilitate, action by the agents within them and that those who can take 'positive' action

within an inhibitory framework are exceptional individuals, whose presence indeed serves to highlight the norm of powerlessness.

Euan's account of partnerships, however, illustrated the way in which two areas, broadly similar in that both were hospital wards within the same health board caring for people with acute and severe mental health problems, could nonetheless provide a very different approach. The one that Euan described in detail in the interview was one within which considerably fewer clients were held under a section of the Mental Health Act. Euan considered that the voluntary status of clients was not that their problems at the time of admission to the unit were any less severe than those of clients admitted to the other hospital (to which he had been previously allocated), but that the approach by the staff to clients was qualitatively different:

> Euan:
> ...they [staff] work in such a way that they try to work in partnership with, with the clients as well. You know, um [pause] when patients are admitted to the ward, you know, it's, you know, "Come in. Have a cup of tea", you know. They do the admission when it's appropriate, which would depend on [indistinct - severity of client's problems] and they sort of chat to them, much more [than in the other hospital]. And in that period, where they're chatting to them, they, they try to get them to understand that this is a partnership and try not to use any sections of the Mental Health Act. So, therefore, there are certain things which are acceptable and not acceptable and...the patients *respond* to that and, what's interesting is they're no less, or no more, mad than the people at [the other hospital]. But, because they're treated with basic human dignity and respect, they respond...
> (Interview 24:pp 4-5)

When I asked Euan to identify the factors that he considered made the difference in the care between the two wards, he said that the area in which the partnership approach was fostered was smaller in size and that the medical and nursing staff seemed to work together, with the medical staff listening to the nurses' comments about the clients. Euan described the care as being a team approach and emphasised that this included incorporation of the client as a member of the team. He did not consider that the unit was better resourced, indeed some of the facilities were less modern than those in the larger unit. So, it appeared, in Euan's account, that the smaller unit facilitated a closer relationship between different occupational groups and active inclusion of the client within this. When the nursing staff's intimate and sustained contact with the client is acknowledged, this

may result in provision of treatment and care that are contextualised to the individual and also leads nursing staff to perceive that their contribution is valued, rather than denigrated. This situation is likely to facilitate and generate more positive relationships between all staff and clients and enable the latter to be perceived as individuals.

Euan spoke of one of the medical staff within the above placement:

> ...who was spectacularly good because he responded to people as people, um, and got a *huge* amount of co-operation out of patients...because they felt they were able to talk to him...I feel that medical students and nursing students should have a lot of common studies. I think we should be, social and behavioural sciences and, ah, communication skills to be together. So that we're all coming from the same base, em, level. Because, doctors without a bedside manner are really inexcusable...
> (Interview 24:p 8)

So, in the above, Euan identified, not only the positive nature of partnerships between staff and clients, but that these were only possible when the traditional notion of professional distance was discarded in favour of one in which all parties were assumed to have equal status. It should be said that the students' highlighting of situations in which medical staff did behave as equal partners in care was perhaps indicative of its novelty value in the general scheme of things. Euan considered that some sharing of the educational preparation for practice which students in different health care occupations receive might enhance client care, although it is possible to suggest that some of his comments valorised nursing at the expense of medicine.

Whether such equal partnerships are desirable in each and every circumstance is, of course, open to debate. It was a point discussed by Jim, who pointed out that:

> ...people are very anxious in hospital a lot of the time and they [pause], they see doctors maybe being a sort of bastion of security. They see some security in them. I know I feel like that...
> (Interview 30:p 6)

So, the reality of the remote doctor/client relationship, in which the former maintains a 'professional distance' may, at least for some individuals, in some situations, provide a security that they may crave in a situation in which they are

anxious or fearful. Whilst in some respects 'professional authority' may be intimidating and patronising, it enables a feeling that someone holds knowledge, expertise and control. The intermittent and possibly ceremonial nature of the doctor/client encounter may, then, offer a positive perspective which is ignored by those who advocate and implement policies which emphasise equal partnerships in care. Contrary to Euan's comment that medical staff who were approachable were positively perceived by clients, Jim's indicated that at least some individuals appeared to prefer a more distant and authoritative approach.[41]

The extent to which the notion of partnership between client and staff is achievable is also determined by a number of factors which, although infrequently accorded formal status as barriers by policy makers, may impede or preclude the possibility of equality. Examples of these are age, socio-economic class, ethnic origin and gender. As the focus in this thesis is upon the students' perspective, it is my intention here to confine myself to identification of the existence of such barriers, as perceived by the students, rather than attempt any detailed exploration in depth of their effects upon patients/clients or carers.[42] That patients/clients have identified themselves, or been identified by others, as having health care requirements for which they require to seek expert assistance, places the former at a disadvantage vis a vis the latter. The wearing of uniform by many health care professionals reinforces their status and the wearing of everyday clothing, or in many settings, nightwear, by clients reinforces theirs. None of this predisposes towards the formation of equal relationships, even in the absence of issues related to age, socio-economic class, ethnic origin or gender. It was noted earlier that Euan identified the concept of an equal relationship between clients and health care professionals as unattainable in practice (Interview 24:p 1). This was also a point made by Sheila:

> ...even talking to somebody [ie a client who is] in the bath. I mean, they're naked before you in the bath. I mean someone might be, you know, especially the fact that they're male and you're female, you know...it's not necessarily the best place for communication, you know.
> (Interview 14:p 7)

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[41]This of course begs the question of whether such a dependency by clients upon professionals *should* be fostered.

[42]Many writers have provided an exploration and analysis of these factors. Two excellent examples are the work of Hugman (1991) and Davies (1995b).

It is the case, then, that whilst development of an equal partnership between clients and carers may be a laudable ideal, it would appear sanguine and simplistic to assume that policy change per se has the power to transcend the structures and attitudes which have, for so long, held sway. A fundamental appraisal is perhaps required, by practitioners and clients as well as policy-makers, of the role of health care professionals vis a vis their client groups, with concomitant examination of the organisational framework of current health service delivery. A consequent agreement by all parties that change and redefinition are required would appear to be a prerequisite for successful and sustained changes in practice.

Informal care providers

The role of the client's 'informal' carers was identified, for example by Sheila, in relation to the care of children with learning difficulties, who quite frequently had concomitant physical disability. In discussion of a community placement, in which she accompanied the registered nurse on visits to clients' homes, she identified the care provision as being of a high standard for a number of reasons, one of which was that the nurses:

> Sheila:
> ...respected the fact that these clients were inviting them into their homes, you know...You know, certainly, mothers with children with learning disabilities, you know, they really respected the mother, as the person who knew the child best...they didn't try and come in and say, "We have all the answers". And they respected [pause] they acknowledged the difficulty a mother with a learning disabled child would have...how draining it, it could be...and were really supportive, very supportive. And didn't try to sit, you know, they wouldn't try and sort of preach at the, you know, parents of the children or that. And with the adults [ie clients], again, you know tried to treat them as adults and that and, you know, encouraged them to do what they could for themselves...
> (Interview 19:pp 13-l4)

So, in this setting, the clients' carers, as well as the clients themselves, were regarded, not only as partners in care, but as frequently the more knowledgeable party in relation to the client's individual needs and the optimum means by which these could be met.

Partnership, not friendship

Although the preceding section emphasised the positive effects that partnerships in care might achieve, it should not be supposed that this achievement was invariably accompanied by the presence of positive emotions at the level of interpersonal interaction. Sheila found it noteworthy that, despite the ability of nurses as individuals to provide high quality care, and to meet and work as a team in the discussion, planning and co-ordination of care with their co-workers, there were, nonetheless, personality clashes.

> Sheila:
> ...So, they weren't a very good team really, you know. Em, they didn't really work well together at all. Not just because of the one who domineered, but just generally speaking, they weren't a good team. Yeh. Individually they were fine though, yeh.
>
> Dorothy:
> Yeh. Did you feel that they didn't get on that well as a team had an effect on the care the clients got, or not?
>
> Sheila:
> No, for some reason it didn't, you know? I don't really understand why, but you know? Each of them got on well with the psychologist and the psychiatrist and the physio. and the O.T.[43] and that, you know. So, that was fine...they asked each other's advice on the clients, you know, on their caseload. And they did talk to each other you know, but there was always, you know, under the surface...
> (Interview 19:pp 14-15)

In the foregoing, it can be seen that individuals working in team partnership could succeed in providing good quality care, despite the existence of interpersonal disagreements. A mutual respect for one another's professional expertise and opinion was not predicated (in this instance) upon personal liking.

Inter-occupational partnerships

Jane described one of her hospital placements within which the multi-disciplinary team appeared to function well. This was also an area in which 'paperwork',[44] a

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[43]occupational therapist
[44] ie, the documentation of client care

theme accorded a separate section later within this chapter, was viewed in a positive light, a fact which was resultant from the inter-occupational partnership ethos prevailing within the placement. Jane had spoken in earlier interviews about the beneficial effect on client care of working within a multi-disciplinary team (for example in her community placement, cited earlier) and this was a theme which continued, albeit accorded less discussion time. Weekly meetings of all staff involved in direct client care enabled sharing of information and Jane considered that:

> ...it really made a difference to the care of the patient...you weren't phoning up 'a dietician', you were phoning up 'Lynne, the dietican'...and she knew the patient...
> (Interview 27:p 10)

In that particular placement, all members of the multi-disciplinary team contributed to the clients' ongoing progress notes. This included personnel external to the placement, but who had involvement in the client's care. for example radiologists. Jane contrasted this approach, in which only relevant information was documented, with some other placements in which reports were written about each client, even in the absence of any change in their condition or needs. She identified that, in order for it to be effective, much greater accuracy in careplan compilation and update was required than she had encountered in many of her other placements. So, here, involvement of the multi-disciplinary team and scrutiny of nursing documentation by other occupational groups resulted in higher standards of record-keeping.

Summary – partnerships in care

In summary, the students' perception was that partnerships in care were effective when those involved in health care provision acknowledged the importance of the client as one of the partners. It was insufficient for lip service to be paid to this; the rhetoric required to be translated into practice. The formation of partnerships between clients and carers was facilitated by settings and organisational frameworks within which development of a sustained relationship was possible. Examples of this were community settings and also institutional settings in which primary nursing was implemented. It is important to note, however, that, whilst such sustained contacts existed in Alan's mental health and care of the elderly

placements (discussed earlier), these did not have positive outcomes in relation to care provision.

Involvement of the client's informal carers as partners, where appropriate, resulted in improved quality of care as a result of the use of their knowledge and expertise. Partnerships between clients and their informal carers and the professional health care team entailed explicit acknowledgement that the latter group did not possess a monopoly on knowledge and decision-making. A prerequisite for formation of such partnerships was, indeed, relinquishment of the traditional concept of 'professionalism'.

Partnerships between the different occupational groups involved in health care provision entailed an inter-dependent approach, rather than one in which each group endeavoured to act autonomously and protect their own considered field of expertise against all comers. Such partnerships co-operated and communicated within a multi-disciplinary team in order to integrate the assessment, planning, implementation and evaluation of care provision. This process was facilitated when the members of the team were known personally to one another, although it was not the case (as highlighted in Sheila's account) that they required to have a personal liking for one another but, rather, a mutual respect for one another's contribution to care.

It is important to note at this juncture the provisos made within the above. It was noted earlier that the relationship between clients and professional caregivers is not automatically an equal one and, similarly, that the relationships between members of the different occupational groups (and, indeed, within the same occupational group) involved in the delivery of health care may be unequal. As was highlighted in the section on medical hegemony within health care, it is the medical staff who have the greatest authority, both legally and in less tangible, but nonetheless powerful, terms. Partnerships are only likely to succeed when medical staff relinquish some of their traditionally-held authority and acknowledge the contribution of other occupational groups as being of no less importance than their own. Similarly, nursing staff may be reluctant to accept that other occupational groups, the client, or their informal carers, are equal partners in care provision. It would appear to be the case then, that, whilst the organisational framework or the prevailing ideology may propose that partnerships in care constitute the future modus operandi, the individuals and occupational groups who work within this

require to make adjustments to long-accepted perceptions and behaviours in order to translate the rhetoric into practice.

Methodological note: Partnerships

It was noted in the opening paragraph of this section that the theme of partnerships in care was clearly emergent following the students' community placement within their branch programme (ie during their third interview). In the interviews prior to this point, however, although the multi-disciplinary team was sometimes mentioned, the concept of partnerships, per se, was not identified. In subsequent interviews, partnerships were not accorded the emphasis placed upon them in the third interview and, in some instances, they were only explicitly discussed if I referred to them and asked the student for their current perspective. It may be argued that, as with the concept of institutionalisation, diminishment of novelty value, whilst not negating the importance of the concept, reduced the students' identification of it as a theme requiring rehearsal.

Organisational impact of the 1992 Programme

Within the Appendix, the historical background to the 1992 Programme undertaken by the students in my study is outlined, as is their preparation for practice. The students operated within two organisational frameworks during their Programme; higher education and health care, although their primary affiliation was to the former for the duration of the Programme. These organisational frameworks impacted upon the students' experiences, sometimes in a way which enhanced their learning, but at others in a way which created conflicting loyalties. This section will explore the effects exerted by the structures within which the students, the staff within practice placement settings, and the clients, interacted.

Symbolic interaction, whilst acknowledging that individuals act according to the meaning which they, as individuals, attribute to the situations they encounter, has been criticised for its perceived failure to provide a comprehensive explanation of all behaviours that may occur. In its emphasis upon the individual as active agent, it may fail to accord adequate importance to the structures that pertain and which may facilitate, inhibit and limit the actions (and inactions) available to individuals.

Indeed, it may be a sanguine and simplistic expectation that any one theory can serve to explicate fully the complexities of human behaviour. It may be argued however, that acknowledgement of the importance of structure is perfectly possible within an interactionist perspective. The structures contain symbolic meaning for those who operate within them and they will respond to this in accordance with their own individual prior life experiences. Whilst the influence of the structures is obviously considerable, there is nonetheless the potential for individuals to comply with these, or to resist them. The extent to which this is, or is not, viable depends upon the symbolic meaning of the structures to individuals and the resources (physical, intellectual and emotional) which they possess.

The following section will examine the students' views of the organisational effects which influenced the abilities of individuals involved in care delivery to implement it. The students' views on the role of the individual, discussed within an earlier section of the chapter, will then be reviewed in the light of the findings from this section, in order to identify the relative importance of each in the students' perception.

The data from the initial interviews demonstrated student identification of organisational factors which had the ability to facilitate or, more commonly, inhibit care delivery of an acceptable standard. At first, as discussed earlier, students appeared to place the onus for acceptable care delivery upon individual caregivers, irrespective of the organisational constraints under which they were expected to operate. This was interesting because, in relation to themselves, the students viewed the organisational constraints, both those imposed by the university and by the practice placement, as rendering them virtually powerless to effect any changes, or to ensure personally that care delivery was of the desired standard. If a frame analysis approach is taken here, it would appear that, initially, the students saw themselves as being to some extent apart from active involvement within the placement frame, this being the domain of permanent staff. This effectively distanced students from viewing themselves as *agents* within the frame activity. They were agents only within a student frame, their transient and junior status according them immunity from responsibility for the permanent frame within which they were transient visitors.

Whilst it is obvious that the students did not refer to the care setting in terms of frames, their comments in earlier interviews indicated their perception of

themselves as spectators, as opposed to agentic participants. In some instances this was overt, as in George's comments about his early mental health placement:

> The first couple of days weren't anything that I expected at all. Because, I expected that I would kind of, I don't know, get down to it straight away. It would kind of be, right, take you on board. You're a student, you're here to learn, get your hands dirty - or, you can sit on the edge. And, hopefully, I'd hoped it would be a 'get your hands dirty' approach. [pause] But they were very much stand-backish...And I was, I didn't really want that kind of thing, I wanted something different.
> (Interview 10:p 3)

It can be seen from the foregoing that George's exclusion from the frame's activity was not what he wanted and he voiced his disquiet to his mentor, although it was not until the end of the second week (the placement was of five weeks' duration) that he had an opportunity to do so.

> Dorothy:
> ...So, did you feel eventually you got the 'hands on' that you were wanting?
>
> George:
> Yeh. I think after, when the charge nurse got the chance to sit down, I was able to say, "Well, I want the 'hands on' approach and learn that way better". So, from then on we, she kind of adopted that [approach] with me. [pause] So, that cleared the air between the two of us. Everything was better understood after that. So that was really good. And I got a lot more out of the last three weeks than I thought I would do at the end of two weeks, so, it was really good.
> (Interview 10:p 4)

So, in this instance, exclusion from the frame caused the student unease, rather than relief, and an active negotiation with his mentor resulted in his inclusion, with support, in the frame's activities. This active participation resulted, for George, in a more meaningful experience than would have been gained had he remained on the sidelines of the frame as a student bystander.

The use of Goffman's frame analysis

Whilst Goffman's (1974) concept of frame analysis is useful, it should be said that its limitations were highlighted by interviewing the students on a number of occasions, as opposed to one occasion. Had the latter approach been adopted, a

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clear 'student frame' might have been 'identified'. The data from each interview, however, revealed a slightly different conceptualisation of the 'student frame'. Whilst this overlapped with its predecessors and successors, there were nonetheless discernible differences in the frame, as the students gained experience and acquired access to what some termed, 'the wide picture'. Although I found the concept of frame analysis useful in a broad sense, it is important to avoid the danger that it may project a more static, less dynamic, impression of the students' experience than is warranted.

It was stated earlier that students, for most of their practice placement allocations, were accorded supernumerary status and it may be argued that this could also serve to provide a buffer between the reality of the placement frame and the student experience. What did emerge from students' accounts seemed to be dichotomous, students either perceiving themselves as distanced from direct participation in care, as for example during George's initial fortnight in his mental health placement or, alternatively, being regarded by staff as able to implement care to the level of someone at a much more advanced stage in the programme, as in Sheila's experience of being left to decide upon an appropriate wound dressing for a patient.

For some of the students, however, supernumerary status was viewed, at least in the early stages of their programme, as something which afforded them protection against the requirement to participate in care that they perceived as incorrect (for example in relation to the moving and handling of patients), or in some other way undesirable (for example the rapid completion of patient care as an end in itself, rather than a means by which to achieve comfort for the patient). Jane provided examples of both during her third interview, when she said that, if she anticipated situations arising in which there might be tension between what she knew to be the correct method of implementing care and what the placement staff might do, she temporarily absented herself from the immediate vicinity. This avoidance was rendered possible only by her status as a junior, and thus supernumerary, student. Similarly, when she was allocated to provide client care as a junior student, she felt buffered by the knowledge that she was slightly apart from the rest of the care team and could take the time that she felt was required to provide care without experiencing pressure to work more quickly. Jane could, however, foresee potential future problems:

...I was very much a supernumerary, there wasn't any expectations of me, coz I wasn't counted in the numbers...but, had I been a term 8 student, should I be going back to that ward, in term 10...I don't know if my assessment will come up to scratch coz I think they'll expect me to give in to the guidelines of, "Get your patients up, washed and [pause] I think there'll be a lot more expectations of *me* than there was in term six.
(Interview 18:p 11)

At our fourth meeting it was clear that Jane felt able to express disquiet about care that she considered to be less than satisfactory. I asked her to explain this in more detail and she replied as follows:

...I mean, I've had five placements since we last spoke, um [pause] and now I suppose I realise that supernumerary status actually means nothing [laughed] and it's probably an ideal. An ideal I was looking behind, you know? [laughed]
(Interview 27:p 6)

Upon reflection, prior to completion of her programme, Jane regarded her earlier reliance upon supernumerary status as being similar to that of 'the emperor's new clothes'. It was something much talked-of as providing protection for the student, and she had consequently used it as an amulet to protect her against active confrontation with staff, whereas, in retrospect, it was never the tangible entity of her earlier assumption. It can, of course, be argued that at the time at which she placed reliance upon it, that very reliance did indeed serve to protect her.
The ability to view the client 'in context', deemed by the students over time as being a prerequisite for the delivery of good care, was inhibited by inhabiting a student frame. Jane spoke, in her fourth interview, of inclusion of students into the main frame activity in the latter part of her programme. She commenced our discussion by saying that she felt that she was now (at the end of her programme) able to look at what she termed 'the wide picture'. I reminded her of a comment in one of her earlier interviews, in which she had discussed the care provided for a woman who had ovarian cancer and metastatic spread. She had queried with placement staff why the woman had not been informed of the terminal nature of her illness, but felt that she was unable to comment about whether this medical decision had been appropriate, as she did not have access to all the information

about the client and little opportunity to discuss it in detail with the placement nursing staff. I asked:

Dorothy:
...you said at that point [Interview 12:pp 15-16] I think, that, "I wasn't sure. I didn't have the whole picture". Do you feel, now that you're more senior, that people are giving you the whole picture, so you can make more of a?

Jane:
Definitely. It's something that, through term 10 anyway, I felt quite [pause], what's the word? It bothered me anyway that em, that you felt that you were only getting, at the beginning of term 10, you were only getting so much information. You were getting the information that the staff nurses wanted to give you and any other, sort of problems, you were shielded from, and cushioned from, which didn't help you, I think, to get the whole picture. But certainly, in my management placement, yeh, you got the whole [pause] you got a chance to get in and get the whole. And I think even, on my elective [ie term 11], because I had identified that I didn't have the information that I, I wanted, to make whatever judgement about things, I was asking for it. Maybe it's just getting more assertive at the, at the end of the day.
(Interview 27:p 2)

In the foregoing extract, a number of relevant issues are highlighted. The feeling of being an observer, whilst it might be viewed positively from the perspective that it eliminated or ameliorated stress or disquiet that students might otherwise have experienced in relation to responsibility for care delivery, nonetheless created unease of a different nature. Students wanted direct involvement in the main frame activity and to be viewed by staff, clients and themselves as active providers of care, rather than as mere onlookers, the parameters of whose student frame precluded participation. In their perception, only immersion in the direct 'hands on' delivery of care enabled them to access the experiences required to become registered nurses and to acquire the knowledge of the 'wide picture' which they deemed necessary in order to become proficient practitioners. In both George's and Jane's accounts, attainment of the 'wide picture' entailed an ability to be pro-active and to identify and request the information and activities required to provide care. Acquisition of 'hands on' experience by means of being 'pushed in at the deep end' (a phrase used by several of the students), whilst more stressful and less positively perceived, was nonetheless usually regarded as useful, in that it

provided a trade-off for the student in acquisition of increased expertise. Jane, for example, in discussion of her term 11 placement, said that:

> ...there was scope for me, you know? Um, I was taking charge of a side[45] and a wee bit it was like getting pushed in at the deep end, I think. They were short [staffed] one day, so it was, "You take that side". Um, when I look back, I don't see that as a negative thing. For me - I was ready. I, I wanted it, I was ready for that sort of, next challenge, you know? Em [pause] and I think that's given me the confidence. *One* good placement, at the right time. (Interview 27:p 7)

Acquisition of experience in this manner was not always successful, as for example in Sheila's account, in which being 'pushed in at the deep end' resulted in an inappropriate choice of wound dressing for a client. It is of interest that neither Jane's nor Sheila's experiences were planned for the student's benefit but, rather, arose out of the necessity imposed by inadequate staffing levels. However, the outcomes were different. Whereas, in Jane's case being 'pushed in at the deep end' occurred towards the end of her programme, at a point at which she was able to cope and make appropriate decisions, Sheila's took place during an early placement, at a point at which it was clearly impossible for her to assume the responsibility thrust upon her by the staff nurse in charge of the ward. So, in the former instance, there was a positive outcome, for both the client and the student whereas, in the latter situation, a client's wound was treated incorrectly and the student felt stressed and disheartened as a result. In both instances, the 'learning' experience was not designed to fulfil any educational purpose and the fact that learning of a positive nature occurred in Jane's case was serendipitous.

The notable exception to an acceptance of being used as a 'pair of hands' was the students' nursery placements, in which the students' perception was that they were being used, without receiving an adequate return. As this area was discussed in some detail in section one of this chapter, which discussed the nature of nursing work, it will suffice here to say that the negative, and indeed hostile response,

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[45]When a team approach to nursing care provision is adopted, the geographical area of the placement may be divided into what are colloquially referred to as 'sides'. Staff allocated to 'sides' have responsibility for the care of all clients within that designated area. This might literally be one 'side' of a 'Nightingale' long, open ward, or, alternatively, comprise a number of small rooms.

which such use of the students engendered, may have been attributable to their perception that the care of healthy children is *not* nursing work.

It was the case, however, within subsequent interviews, and most notably at our final meeting, that the students demonstrated an increasing awareness that the problems which they identified in relation to others would soon be their own. Using the concept of frame analysis, it might be said that the students perceived that their current operational frame which, whilst rendering them powerless, also freed them from responsibility, would soon be irrelevant and would be replaced by that which accorded them agentic status within the area of care delivery.

It was also the case that students at times expressed some uncertainty as to what constituted 'good' or 'bad' care within the placement frame. For example, Jane, in her description of her early mental health placement experience, said that she found it difficult to assess what did, and did not, constitute care for people with such problems (Interview 5:p 8). This feeling may have been compounded by the tactic of qualified staff, seemingly prevalent in many of the students' mental health care allocations, of sending students in to 'talk to the clients' on their first day of placement, but denying them access to any prior information about the clients, lest such knowledge bias the student's attitude.

Similarly, Alan experienced uncertainty as to whether he was in a position to pass judgement on the standard of care provision in his mental health placement. He considered that staff were hard on the clients, in that they frequently shouted at them and were physically rather rough when implementing care, but he qualified his comments by saying that:

> Maybe I've not been in the business long enough, maybe I'm just coming in fresh-faced...But they [staff] just seemed awful hard, you know?
> (Interview 6:p 8)

The students' awareness of their own lack of knowledge and experience created some uncertainty in their minds about the quality of care although, as can be seen from Alan's comments, their prior life experience, and their expectations of placements, led them to a feeling that the care that they witnessed was satisfactory or otherwise. It illustrates well the initial thinking of some of the students that, somehow, the placement staff must be right and that, if the student had doubts about the care, then that was resultant from their own lack of experience as to

how things worked. At the same time, some doubts were raised in students' minds about which factors constituted organisational constraints and which factors, on the other hand, were used by some members of staff either as an excuse for unacceptable care, or indeed, to opt out of active care provision. One example, which illustrates this well, is that of the paperwork required in the assessment, planning, implementation and evaluation of client care. This is an area which is discussed in a later section of this chapter.

It can be seen from the foregoing that it is frequently difficult to distinguish between the behaviour of the individual and the effects exerted by the organisational framework within which he or she operates. The individual is limited by the constraints of the organisation but, equally, the purpose of the latter may be thwarted by the former. So, whilst power is exerted by those in charge, its effects may be resisted by those who are supposedly subordinate to it (cf Foucault 1980). Within the same organisational framework it can be seen that different individuals respond and react in different ways and it is then difficult to distinguish between the care that *results* from the organisational framework and the care that occurs *despite* it. Whilst this potential for resistance holds good, the students' accounts, especially in their later interviews, suggest that the organisational framework is likely to be a major player in facilitation, or inhibition, of care delivery, ie in influencing, although not necessarily determining, the range of responses available to individuals within that setting. If the framework within which care is provided constrains the ability of staff to deliver satisfactory care, then it is only the remarkable, rather than the average, individuals who can ameliorate, if not overcome, this and emerged unscathed themselves.

Organisational constraints upon students

Successful completion of practice placement allocations, as was said earlier, entailed achievement by students of 80% of the available learning outcomes, identified in a printed booklet which students took to the placement for completion by their mentor. Action was taken in the event of a student failing to achieve a satisfactory assessment, this being discussed between university and service staff, in conjunction with the student. Copies of all assessments, both theoretical and practical, were lodged within the students' files. Unsatisfactory theoretical assessments required to be resubmitted and awarded a pass grade prior to the students' progression within the educational programme. In some

instances, an unsatisfactory practice placement assessment (dependent upon the specific areas of concern) required satisfactory repetition of the experience, although not necessarily within the same placement area, prior to further progression. Clearly, both theoretical and practice placement assessments have the potential to impact upon the student's future following completion of the programme, as references to potential employers utilise their content. Thus, pressure is exerted upon students to complete all aspects of coursework successfully, in order to remain within the programme and to enhance their future employment prospects. This may generate a considerable amount of stress, as preparation for theoretical assessment submission frequently overlaps with practice placement experiences. Successful completion of the course requires considerable time management skills, as many students have domestic responsibilities and financial commitments that quite frequently necessitate part-time employment outwith the course. Some students manage this juggling act with relative ease, whilst for others it generates considerable pressure, which for some stretches, or outweighs, their ability to cope.

The above issues were identified by Jim, in relation to himself and to other students and his account highlights many of the problems discussed by other students. Students who undertake the 1992 diploma programme receive a bursary which, whilst considerably larger than a student grant, nonetheless requires a considerable number of students to seek employment in order to increase their income to a level that meets their financial commitments. The extract from Jim's final interview highlights the problems attendant upon the foregoing and also illustrates well the point that themes interact and inter-depend, as opposed to being discrete entities.

Jim:
...I think in many ways...being a student nurse doesn't really, doesn't really help you much in, in your approach at times. Some days you've got other things on your mind, you know? Like, lack of finance for instance and a lot of students suffer from that. And sometimes you're maybe not quite as [pause] sharp on the job as you should be, I think. I, I mean, I had a friend who suffered very badly from that and he suffered so badly...he had to go back, take three months out and stuff. And, basically it was all financial trouble, you know? So, there's a lot of things that affect your, your, yourself in the job. It's not just working in, in the hospital. It's the whole, total situation as well...at times more difficult than others to switch off. Sometimes it's easy, you never think about it, all you think about's your job and then,

other times, it would mean, I don't know, it never happened to me, but if you were getting baillif's letters, or, you know what I mean. There are certain things I think, pressures that students have, that maybe [pause] other staff, well, they have mortgages and cars and all this stuff, but I think, you know, pressures of studying...

...Maybe in the first year I was a bit more enthusiastic, second year I was kind of [pause] just as enthusiastic, but the latter part of the third year, I found's been more difficult, the nearer, the nearer the finishing line you get...And I don't really think that helps the way you function...[Jim had employment as an agency nurse, sometimes within the same institution within which he undertook practice placements] And then you find all you're doing is working in a hospital. And it's easy to burn yourself out, I think. I think it's quite easy to lose your enthusiasm in nursing, if you do it too often. I think. You've got to have the contrast, you can't just be a caring person all the time [laughed]. You go home and people want hugs and stuff like that and you're, "Leave me alone!" [laughed] It does, it does affect on your, your private life as well, I think. I mean, an ideal night for me is just sitting, by myself, you know, no-one talking to me, just watching the TV. Now, I'm, I'm not like that normally, never used to be anyway...There are a lot of things that I think have changed slightly and you can't just cope by going to the pub because (a) you can't afford it and, secondly, it's not very healthy. Ah, so, there's trying to find decent coping mechanisms as a student is, is - I used to go swimming a lot, but eh, you, at the end of a shift sometimes you're really quite tired. You know, not doing a lot of physical work, but you're, you're just [laughed]. I don't know why you get that tired, but it makes it a bit more difficult to re-charge yourself. That is, that affects personally the way I functioned... (Interview 30:pp 3-5)

So, whereas Sheila's earlier account focused upon the effects which overwork, or at least excessive commitment, may have upon qualified staff, Jim's addresses the effect which it may have upon the students' physical and mental health and, consequently, upon the quality of patient care that they are able to provide.

The pressures upon students of studying for, and submitting, theoretical assessments and achieving satisfactory reports in their practice placements is compounded by the stresses attendant upon having to seek and maintain additional employment as a financial necessity. That the location of this extra work is frequently in similar settings to those in which they are placed as students has advantages, identified by students as providing additional experience which they could then transfer to their practice as students. However, the negative side, in addition to physical tiredness, is the emotional toll that such work may exact.

(cf. the work of Hochschild 1983, James 1986, 1992b and Smith 1988, 1992.) The cumulative effect of these financial, physical and emotional pressures may be such that the student's functioning is impaired, sometimes to the extent identified by Jim, whose friend had to take a break in training, in order to resolve some of the difficulties. In some instances such pressures may preclude the student's return, or lead them to resign from the course, rather than opt for the 'time out', which a break permits.

Summary: The organisational impact of the 1992 Programme

It can be seen, then, that whilst the reorganisation of nurse education and its separation from the service provision was intended to facilitate and enhance the student learning experience, students within the new programme quite frequently have to contend with financial hardship exceeding that experienced within the previous system, in which they were salaried staff, entitled to unsocial hours payments and subsidised accommodation within health service estates. In some instances, the financial burdens that students may carry are resultant from the wider entry gate into nursing. The majority of students on the pre-1992 programmes were school-leavers, or individuals who had recently left school, the majority of whom had no dependants. Many students now commence nursing at a later age and have financial commitments related to home ownership or rental and/or to childcare. Following the reorganisation students may receive a more educationally-driven experience although, as can be seen from their accounts in this study, this is not always the case. On the other hand, however, rather more students than previously have concomitant concerns related to domestic and financial commitments, which for some may be sufficiently severe to negate the supposed advantage of having fewer hours in placement and university and more time allocated to study.

Paperwork: The paper chase

Introduction

Some form of record keeping is carried out by all occupational groups involved in the delivery of client care, but for the purposes of this thesis the focus will be upon that which is the responsibility of nursing staff. Written records purport to form a

visible account of the client's care assessment, planning, implementation and evaluation. They are of ongoing value in the period during which nursing care is required, being accessible, for reference and recording purposes, to all nursing staff responsible for client care. Following a client's discharge from the care setting the documentation of care is retained and may be re-utilised, either as background information in the event of the client's re-admission, or as evidence of the care provided, should subsequent queries arise in relation to this. Client care records constitute legal documents and should be of a standard such as may be utilised as evidence in a court of law. The UKCC places considerable emphasis upon the importance of adequate record-keeping and, indeed, has a publication specific to the topic (United Kingdom Central Council 1998). Within the university setting, from an early stage within their programme, students receive teaching input and information about the documentation of client care and considerable emphasis is placed upon its importance.

The subject of paperwork was raised by students in the early interviews, as an activity that they had not anticipated would occupy such a large amount of the charge nurse's time. In all interviews, it was viewed at best with a degree of ambivalence, due to its time-consuming nature and effective removal of the nurse in charge from the realm of direct care delivery. The irony that responsibility for care delivery then devolved to those who were less qualified to deliver it, was not lost upon the students but, in the early stages of the students' programme, it was accorded a rather baffled acceptance as constituting a necessary evil. As the students progressed through their programme however, this was superseded by a less benign view, the suggestion being made that some staff used the paperwork as an excuse to absent themselves from care delivery, which they viewed as a more menial, and less specialised, activity. Students also identified that the amount of time spent on the documentation of care did not appear to correlate to the quality of care provision: indeed in some placement areas an inverse relationship appeared to exist between the two. Paperwork was discussed spontaneously during interviews as an ongoing theme throughout the students' programme, but the comments made by Sheila encapsulate well the tenor of the students' perceptions as a whole. At our first meeting, Sheila immediately identified paperwork as being an area of importance, her comment within her opening remarks being that:

> ...I think that the nurses were very, very busy with paperwork...they
> expressed a continuous tension between the feeling that they were not, you

know, the longer they were nurses and the more responsibility they got, you know, as they became more senior, they felt this tension between you spending quality time with the patient, clients and, you know, trying to get all the demands of the paperwork done.
(Interview 8:p 2)

This emphasis upon paperwork completion entailed that most of the direct delivery of client care was carried out by auxiliaries and that these were the personnel with whom Sheila spent most of her time. Indeed, on occasions when Sheila did seek out her mentor:

...she would be writing at the desk and she would keep on writing, you know? Indicating obviously [laughed] that, you know, "I don't want to talk right now". So, that was quite difficult, you know. I mean, she always, she was very nice and she was obviously trying [laughed], but it just didn't seem to work out, you know, very well.
(Interview 8:p 2)

Having said that, Sheila considered that the care provision by the auxiliaries was of a good standard and also that they provided her with support, although some of her ability to cope with the placement stemmed from her own prior experience of working within a nursing home and caring for people who had dementia.

By the time we met for the third interview, Sheila had become more sceptical about the necessity of some of the paperwork. She described a placement for people who had learning difficulties and the way in which staff rushed through the clients' care, although there appeared to be no external requirement to do so.

Sheila:
...I think they had a lot of paperwork and that to do. And some day[s] [indistinct] you were busy, but it wasn't like that, crazy...

Dorothy:
Yeh. Quite a lot of people say things about paperwork and that seems to stop quite a lot of care going on. [Sheila: Yeh] How did you feel about the paperwork? Did you feel [indistinct: both talking at once]

Sheila:
Yeh. I just wondered what this 'paperwork', this all-encompassing term [laughed] is all about, you know. You know, you just hear it referred to, all the time. "Oh, there's so much paperwork!" blah, blah, blah [laughed] and em, nobody has ever actually sat down and explained to me, "Well, the

paperwork involves this, this and this. Which I must ask on my next placement...I mean, writing a bit about each patient each day, I think *is* important, so that you get, you know, a picture of the client...But, you know, there wasn't, they use it as an excuse for a lot of things, which I didn't feel was relevant really, you know?

Dorothy:
What sort of things do they use it as an excuse for, do you think?

Sheila:
Um [pause] whenever they said, whenever they talked about being busy. You know, it was always said, about the paperwork. They were always busy with the paperwork. They were never busy with doing something with a client, you know. [pause] That I think was what, concerned me.
(Interview 19:p 7)

So, over time Sheila, and the other students, shifted from a position of tolerant but puzzled non-comprehension to one of sardonic scepticism in relation to the time allocated to completion of paperwork. As noted earlier, in the discussion of Jane's community placement, it was not the case that the quantity or quality of paperwork bore a contingent relationship, in the students' view, to the quantity and quality of care provision. Indeed, Jane identified that the care delivery was of a very high quality, whereas its documentation was not. Jim, in discussion of his care of the elderly/rehabilitation placement, commented that some patients who had been admitted three months' previously were still without careplans and that the careplans which were compiled were not updated.

Dorothy:
And do you think that actually had a, a big implication for the patient care then, if there wasn't a careplan? I mean, were they used, or [Jim: Nah, nah. Shook his head] were they actually?

Jim:
Nah. I was thinking about that the other day. I thought, I thought, I was thinking about that really and I thought, "Does this make any difference, if I fill in this form or not? So, you know [Dorothy: I mean, it could legally, obviously.] Legally, yeh, legally, but

Dorothy:
From the patient care point of view, does it matter if the careplan's there?

Jim:
I'd like to say "Yes", but I would suggest [laughed]. No, it doesn't matter.
It doesn't really matter I think. I mean, I think it's a good thing, careplans, I
think they're excellent, but I don't see nurses reading them very often. I
mean, occasionally, you, you might see them updating them because you see
them look at them and think, "Oh, that's not been updated for two months".
[laughed] "Better put something in it", but, em, I think it's a good thing for
admission purposes, careplans. Initial assessments and, in certain areas, yeh,
sure.
(Interview 15:pp 17-18)

In his fourth interview, Jim returned to the subject of careplans and cited an area
in which their content bore little resemblance to the care being given. In this
instance, failure to compile and update them was a consequence of inadequate
staffing levels, which gave the nurse in charge the choice of either implementing
the care, or of sitting documenting what, in that instance, would *not* have been
done for the client. Jim designated the care provision as being of high quality, but
the lack of documentation caused problems for those who, like himself, were new
to the area and unfamiliar with the clients and their needs (Interview 30:p 2).

The use of multi-disciplinary notes, in conjunction with good teamwork, was
identified by Jane as contributing to documentary evidence which was relevant and
updated on a regular basis. As this type of client record was discussed in some
detail in the section which dealt with partnerships in care it will not be rehearsed
again here, except to highlight its importance, in the students' view, as a positive
example of record keeping.

A method of nursing care documentation, entitled 'integrated care pathways', was
in place within some of the students' placements. The client's care was recorded
on pre-printed careplans, prepared for an 'ideal' client admitted with a specific
medical problem, or for a specific medical or surgical procedure. For example, a
person who came in for specific surgery would be allocated a standardised
pre-operative and post-operative careplan, based upon the assumption of an
uncomplicated 'textbook' progression throughout their hospitalisation. There was
space designated on the form to note departures from the expected norm, for
example if a wound drain required to be left in situ for longer than anticipated, and
additional sheets were provided for any supplementary material specific to that
client. The motivation behind development of this documentation was presumably

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that of time saving and consistency, but the students were dubious about the contribution of the 'integrated care pathways' to the placements' official rhetoric of promoting individualised care. George, at the end of his programme, spoke about their use as follows:

> George:
> ...I think that there's some ways that they're very good and others where, you know, they don't work at all. They don't leave any scope for individualised care...you have to adapt them. You have to be flexible and adaptable [pause] in, in nursing care because everyone isn't the same, you know. Maybe there's something like hip fractures that will work, but I think that, in the majority of cases, people who come into a ward aren't the idealistic [sic] patient, you know? You know, I think that we have to be able to change the way we work to different people, um, and that you have to have an individualised picture of the patient...
> (Interview 28:p 12)

Jane made similar comments to the above in relation to her first adult placement, in which she felt that the use of integrated care pathways not only reduced the possibility of holistic care, but also failed to achieve the purported aim of reducing nursing documentation and thus saving time (Interview 12:pp 18-19). Later, in the interview at the end of her programme, she expanded upon this when talking of the need to individualise care and view the client in context. I reminded her of her earlier criticisms of the care pathways and asked for her current perspective in relation to their use.

> Jane:
> ...these integrated care pathways only look at one element of the patient, and they're good for that, but what about all the other problems surrounding it?
>
> Dorothy:
> Yeh. So they're ok as part of the care package, but if you looked at them and thought, "This is the care that the patient's to get", that would be a bit misleading?
>
> Jane:
> Yeh. Definitely. It doesn't, it didn't give you the scope to look at other, additional problems. Or, it gave you one page to add in the patient's additional problems, which in my experience - I've just been in a general medical ward and the thing the patient comes in for isn't the main problem. It's it'll be [indistinct] as a result of many other things...I don't think they work. But I believe they're coming more and more into practice now, care

pathways...I think sometimes that, yes, it helps on a timescale thing, but when you're really doing a good assessment on the patient, if you're just going by points one to nine on the careplan you, there's other things you should be asking, as well. I don't think the assessment procedure helps when you've got these...And I think as a student, as early on, that, what you're looking for *are* guidelines, not [pause] Not, not that, I'm not saying you should use your initiative [ie as a junior student], but you're looking for guidelines and something to, to work from and it's a bad practice to get into, if you just look at what's written down on your careplan, you know?
(Interview 27:pp 8-9)

It can be seen that, in the foregoing extract, Jane began her critique by saying that, whilst it was possible that the integrated care pathways could, in the care of some clients, prove time-saving, they encouraged a focus upon specific problems, notably those which were physically observable and involved implementation of psychomotor skills for their resolution. They tended to stereotype the client into a purely textbook pattern of being, that did not accord well with an individualised approach, the latter, of necessity, including attention to psychosocial elements for its successful implementation. Jane then discussed the effect of the care pathways upon nursing staff, in particular upon nursing students who, by virtue of their lack of experience and consequent insecurity, might place an over-reliance upon the elements identified by the pathways, at the expense of the problems which the individual client experienced. Thus, the care pathways inhibited, rather than facilitated, seeing the client in context and indeed decontextualised care to the extent of providing a textbook, generalisable identification of what were deemed to be key points in the treatment and care of any client with that particular medical or surgical diagnosis.

Summary: Paperwork - the paper chase

It is of interest, then, that the documentation which ostensibly facilitates client care has, by its inflexibility, the potential to constrain its delivery to the optimum standard. It may also be seen that the quality of care delivery bore no direct positive correlation, in the students' accounts, to the time spent by staff on its documentation.

Quality of care

Introduction

It is possible to identify factors which, in the students' view, constituted 'good' practice. These were, on some occasions, identified in their own right and on others by their absence, ie if I asked the student to identify an example of good care, they quite frequently commenced their discussion by telling me what this did *not* entail and providing me with a description of such a situation. The students' conceptions of good care were thus frequently ascertained by an initial deletion of factors that they regarded as bad practice and subsequent identification and clarification of the elements of the remainder that constituted good care.

As was said earlier, the theme of seeing the client 'in context' emerged over time as being the core category and a prerequisite for delivery of nursing care of a high standard. This was not something that the students initially felt equipped to do. Within university, the idea that nursing care should be holistic and should take account of the client's psychosocial situation, as an integral component of an overall process of care delivery, was emphasised from an early stage in their programme. It may be argued, then, that students in their own identification of context as central, had merely undergone a successful socialisation process and rehearsed what they had been taught. However, their accounts do not indicate such a straightforward, or simplistic, version of events. Their initial narratives, whilst at times acknowledging the concept of holistic care, did not tend to view it as something attainable by themselves. The ethos within most of the placement areas to which students were allocated was one in which pragmatic realism, rather than rhetorical theory, prevailed. The socialisation process within placement areas may well exceed that which takes place within the university, as it is arguable that students are likely to identify more closely with the latter, as the location wherein their future lies.

Over time, however, the students' gradual acquisition of 'the wide picture' appeared to facilitate an increased understanding of the many factors that may affect the situation in which clients find themselves, at the point at which they are deemed to require health care. The possible reasons for this increased awareness

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were identified and discussed in an earlier section of this chapter. George commented that:

> ...I think that now, having been working in the environment [ie placements]...you see what, what good care is for different people. And, as my ideas become more realistic, they've become I suppose more individualistic as well...different people's independence and dependence, so that my ideas of good care [pause] have changed now...I think that we have to be able to change the work to different people, um, and that you have to have an individualised picture of the patient...I think they [ie his views] they've not changed so much in a large way, just that the rough edges have been smoothed off and [pause] em, my basic idea of coming into nursing was kind of, helping people, whereas now I think it's probably helping still, but just in a different way.
> (Interview 28:p 1, p 13)

An acquired understanding of the importance of contextual issues was not unproblematic for students, in that it brought with it a degree, at times, of uncertainty as to what then constituted care of a satisfactory standard, or otherwise. In one context, for one client, care might be deemed good, whereas for another, in rather different circumstances, it might be inadequate, or insufficient, to meet their needs. Students felt that, over time, their ideas of what 'bad' care might entail remained relatively unchanged, but that their views of 'good' care were less straightforward. As Jim described it:

> ...I think experience changes your viewpoint. The more experience I've gained, I think it's changed in what is good care in some ways, but in what is bad care remains pretty much the same as it's always been. [pause] It's trying to work out what's actually *good* for people. I think that's what's changed.
> (Interview 30:p1)

For Sheila, as noted earlier, increased experience and an ability to view the client in context meant that she felt that she had become:

> ...less judgemental in terms of em, not jumping to conclusions about why people do things...and realising all the factors and how wrong you can actually be when you judge, when you jump to conclusions. It's something I've noticed again, time and again on my placements...you realise that there is always, usually always, more to these situations than meets the eye. And I think definitely, when I started my training, I would have jumped to conclusions a lot quicker than I would now...there are so many grey areas I

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think...and you do have to take each situation, you know? It's always different I think.
(Interview 25:p 12, p 14)

The acquisition of greater awareness of the many issues which might impact upon care of the client, despite its creation of uncertainty, did not appear to cause students undue angst, although it at times created problems in relation to identification of what 'good' care entailed in substantive situations. Although the students noted that situations were less clearcut than they had perhaps envisaged at the beginning of their programme, this was something which, despite being unanticipated at the outset, was seen as an unavoidable, and indeed desirable, part of the nature of nursing.

The nature of nursing also entailed that a prerequisite for care delivery of a satisfactory standard was a ongoing requirement to update practice. The students were aware that successful completion of their programme would not equip them with all the knowledge necessary to deliver good care. Their comments about staff who failed to update themselves on current nursing practice indicated their perception that such an approach was erroneous and led to stagnation. The care that they perceived as being unsatisfactory frequently resulted from a failure to update knowledge and was, as such, to be avoided. This, however, required a reflective awareness on the part of the practitioner and, concomitantly, an openness to suggestions from others as to the means by which enhanced practice could be achieved. Jane's comments encapsulate this aspect of the students' experience:

> ...nursing, I've learnt, is [pause] one of the most volatile jobs you can have. Because things are changing all the time and what was right, or what you thought was right, has now been [pause] not that it was wrong, but it could be improved upon by doing "this", so you [pause] you've got to change again and so...if you sort of like rules and regulations and [pause] a job that's, "You do this, this and this and at the end of the day you can go home", then I wouldn't suggest [laughed] a job in nursing at all, coz you'll be continually frustrated with yourself, coz you're not getting the hang of it, coz things are changing too quickly. Which I think's more of a challenge, coz I've said, at one point I would have been that person...I, I like things to be organised and there's not lots of good opportunities for that in nursing.
> (Interview 27:p 16)

From the above, it can be seen that Jane began her programme with an idea that its successful completion would equip her with the substantive knowledge required to commence, and continue, to practise as a registered nurse. By completion of the programme, however, her views had changed and she realised that, whilst the course might hopefully equip her to employ strategies which facilitate good care, substantive issues are subject to change and require to be ongoing reassessment and revision. This awareness created a fairly radical shift in Jane's own perspective over time.

Another contextual element of relevance was the location in which care delivery was provided. This included constraints within which staff were required to operate, one example being short-staffing, although this substantive issue may also be subsumed under a larger theme of management neglect. Also, as was discussed earlier, there were clear limits, in the students' view, to the extent to which such constraints could be used to justify staff behaviour.

Whilst sensitivity to contextual issues, and subsequent responsiveness to these, were noted as the most important factors predisposing to high quality care, the staff attributes which facilitated, or inhibited, this were identified by students and have been discussed. It seems reasonable here, however, to summarise them. It should be said that, when I asked students to identify the factors that they considered created a high standard of care, it was not unusual for them to provide a mocking, deliberately parodic, 'textbook' reply. I did not, then, see any particular value in making this request in the abstract but, rather, extracted from the students' narratives the attributes contained within their descriptions of 'good' care.

High standards of care: staff attributes

Qualities demonstrated by the staff whom students perceived as providing high standards of care were fostered by sustained relationships between nurse and clients. It should however be noted that some areas, such as Alan's mental health and care of the elderly placements, and Anne's placement with people who have learning difficulties, contained such potential, but that this remained unfulfilled and that these, indeed, were areas cited as being examples of a poor quality of care delivery. It appeared that the potential required to be catalysed by active formation of one-to-one relationships, in which a specific nurse was a major

stakeholder in care provision. This, then, entailed a degree of personal engagement, with an active emotional component in addition to provision of physical care. This was exemplified in the situations described by Jane following her community placement and by George in relation to the implementation of primary care nursing within a hospital setting. It entailed the nurse being seen by the client as approachable and non-judgemental. Complementary to this was experience and concomitant expertise on the part of the nurse and a willingness to act in partnership with the client, rather than to be seen as the 'expert' in the relationship.

In the interview at the end of his programme, Euan referred to the name of one of the characters in Kingsley's *The Water Babies*, Mrs Doasyouwouldbedoneby, as an exemplar of the major concept underpinning good nursing care. Without this attitude, he considered that technical expertise and knowledge were insufficient.

> Euan:
> I think, I still feel that basic human dignity's the biggest tool we have em, to working with people with mental health problems. Um, and the notion that you don't do to people what you wouldn't want done to yourself or your loved ones. And I think that's probably something that I felt very strongly anyway. If anything, I feel more strongly about it, so, yes it's [ie his views on good care] changed in that sense. I just simply feel much more strongly about it. Um [pause] I do feel that very strongly.
> (Interview 24:p 7)

Whilst I earlier referred to the potential problems in assuming that what one individual will desire in a given situation will necessarily equate with the wishes of another individual in similar circumstances, it was nonetheless mentioned by several of the students as a means of ensuring good care. It was also the case, however, that doing to others as you would have them do to you did not, in the students' accounts, refer to substantive actions or inactions but, rather, to principles which might underpin these, for example respect for clients as individuals, care for whom comprised more than a generalisable principle of attention to their health care deficits. It was, indeed, this latter point which generated some of the criticism directed at medical staff and might, in the students' view, necessitate nurses acting as clients' advocates.

Advocacy

Much discussion, written and verbal, has taken place in recent years in relation to the possibility, or desirability, of nurses adopting an advocacy role in relation to clients, in instances in which the latter are unable to explicate their wishes, for whatever reason. Those who consider an advocacy role desirable (including the United Kingdom Central Council), propose that the sustained contact between nurses and their clients enables access to their views and representation of the client's interests to third parties as required. Those who urge caution, or who think that an advocacy role is an undesirable one for nurses to adopt as exclusively their own, may do so for a variety of reasons. Some argue that the very closeness of the relationship between the client and nurse (coupled with the power inequity which usually pertains within this) precludes an impartial perspective and that potential problems arise if the nurse's view of what is in the client's 'best interest' is at variance from that of the client.

The notion of advocacy was derived from that within the legal system and it is arguable that the eagerness of some nurses to adopt it as an integral component of their own role is due to its links with an occupation traditionally regarded as being a 'profession'. Another problem is that advocacy entails an adversarial role for the advocate, against someone else. The adversary in a health care setting is usually another health care worker, most frequently the medical staff. If nurses identify themselves as clients' advocates, this may imply that those in other health care occupations are unconcerned, or at least less concerned than are nurses, with acting in the client's best interests. It is arguable that, in health care, such potentially confrontational roles are inappropriate for workers to adopt vis a vis one another and that interdependent cooperation amongst all involved in the delivery of care, including the client, is a more appropriate model to adopt. Notwithstanding these identified problems, advocacy is a role that many nurses seem eager to adopt. Some of the students in my study regarded it in a fairly favourable light and considered that the potentially confrontational aspects were, in some instances, necessary. As Euan commented:

> ...we should be up to challenging the, eh, medical profession, you know? Asking them to justify themselves, and that's about being the patient's advocate really, isn't it? You know? Saying, well, "Why do you think that's appropriate?" You know?

Dorothy:
So, you would see being a patient's advocate as being an important part of the [Euan: Yes] nurse's role, yeh? [Euan nodded]

Euan:
And we need to be doing that. We need to be pushing those boundaries. You know?

Dorothy:
Mmm. So, if you say that the nurse should be the patient's advocate, obviously if you're advocating on somebody's behalf, you're speaking on behalf of somebody who can't do it for themselves, for whatever reason, against somebody else, so [Euan: Yeh] why is it you feel the medical staff would have to?

Euan:
I feel, because, em, they still essentially look at somebody as, you know, a collection of symptoms, rather than as a person ...
(Interview 24:pp 7-8)

In the foregoing, Euan's rationale for adoption of an advocacy role is that the medical perspective is of the client as a series of health care deficits which await correction and cure, rather than as an individual, whose personal wishes and aspirations require consideration. In this 'bio-medical' approach, the client's care is thus de-contextualised, as opposed to being viewed in the context of the individual as a whole.

I asked Euan whether he had encountered independent advocates in any of his practice placements. Within mental health (Euan's chosen branch) and learning disability settings, the notion of independent, lay advocacy has been developed. The people who adopt this role are usually volunteers and receive a preparation for practice. Their lay status is seen as providing a desirable protection against some of the problems which I identified in relation to health care providers acting as client advocates. Euan had met several such advocates and did not view their role as problematic vis a vis that of nurses. Indeed, in relation to nurses as client advocates he commented that:

Euan:
I'm ambivalent on that because we see a lot of the patient, but perhaps we see too much of them to be a good advocate for them...I can see both sides of the

argument. But in the meantime, I think we should carry on doing it, you know?
(Interview 24:p 8)

Thus, whilst lay advocates had their place, this was not seen by Euan as negating the role of the nurse in relation to this function. Indeed, one problem with lay advocates is that they are not usually available to represent the client's interests on a twenty four hour basis and, even when available, require to be requested to attend. If a situation arises in which a rapid decision requires to be made, it may be unrealistic to expect them to be present.

Underpinning the students' discussion of advocacy was the need to treat clients as individuals, rather than as objects, as the latter approach involved directing care *at*, rather than *for*. Adopting such an approach ran the risk for the nurse of the emotional distress which distancing had the potential to reduce, but it was nonetheless seen as an integral, and essential, component of the nurse's role and not as the rhetorical icing on the cake. Another problem for students in some placement areas, was that their wish to take time to provide individualised care might go against the permanent staff's emphasis upon speedy care delivery and thus distance the student from the possibility of being included in the ward team.

Client 'labelling'

There was an alternative, or additional, factor in some placements, identified by students. Staff might emotionally engage with some clients, but only those for whom they felt a personal, affective link. This created the notion of 'favourites', who received most of the positive attention and, sometimes, labelling of other clients as 'difficult', or in some way as socially unacceptable. Jane spoke about this problem in relation to her placement with people who had learning difficulties. There was a minibus available for use by the staff to take residents for outings, but the selection process entailed staff selecting those who were the most socially acceptable in appearance or behaviour (Interview 12:pp 6-7).

Jane later provided an example of negative stereotyping of clients by staff. She cited one adult physical health placement in which a patient who had problems related to alcohol abuse was admitted. He was truculent with staff, spat on the floor and was generally uncooperative with the treatment and care prescribed. Whilst this behaviour continued the placement staff had a negative attitude in

relation to the patient, but this softened as his condition deteriorated and he became less abusive and more quiescent. Once he accepted the care provision without demur, the attitude of staff towards him improved dramatically and he was viewed in a much more positive light (Interview 27:p 24).

The client as 'the goody': changing perceptions over time

It should be noted that students' experiences did not result in their having a rose-tinted, or otherwise unrealistic, view of the capacity of individual clients to be unpleasant. In Euan's first placement (discussed earlier), which was within a mental health setting, one client declared that she intended to accuse him of rape. Euan commented that:

> Euan:
> ...I think one of the things I found most interesting [about the mental health placement in general and the substantive situation in particular] - and this'll probably sound incredibly ignorant to anybody who's been doing it for any length of time. I think if you're dealing with people who're, who don't have a mental illness, who have a physical illness, something like, let's say a broken arm or something like that. [pause] It's very easy to recognise that that person is unwell because they've got something wrong with them, but they're also a nice person, or they're a shit, do you know what I mean?

> Dorothy:
> Uhuh.

> Euan:
> Whereas it never really crossed my mind when, before I went on this placement, that somebody who was mentally ill could still be a nice person, or a shit. Do you know what I mean? That their mental illness didn't necessarily affect what kind of person they were in society in general? (Interview 4:p 5)

A similar comment was made by Anne, who spoke of one client, who had a domineering and manipulative personality which, whilst partly attributable to her illness, appeared to be an ingrained and integral component of her personality. Anne's problem was that staff granted this client her wishes, even in instances when their fulfilment conflicted with the interests of other clients (Interview 9: pp 10-11).

Jane, in her concluding interview, spoke of the problem of seeing the client as invariably 'the goody' (Interview 27:p 24). She had commenced the programme herself with such a view, but could see, in the light of experience, that this image was not necessarily borne out in reality and that, in instances in which clients' relatives either did not visit, or did so infrequently, she could now see that this might be resultant from longstanding difficulties within the relationship which were, at least in part, caused by the client's behaviours. This revised view contrasted with what Jane regarded as her earlier rather judgemental feeling that those who did not visit, or who did not want to care for their relatives at home, were callous or selfish. A greater awareness of the client in context had provided a wider perspective and precluded preconceptions and formation of rapid conclusions about the position of clients vis a vis their relatives. Indeed, the realisation that clients possessed characteristics which might attract or repel was an integral component of viewing them as individuals in a social context and no longer viewing them unproblematically as 'patients' or 'clients' with generic attributes.

Benefits of task identification

It was also the case that, despite the focus in theory upon the delivery of 'total' care and the move away from fragmenting this into a series of discrete tasks, students did not view a task-orientated approach as being problematic per se. One example of this was provided by Jim, in relation to caring for people who had learning difficulties in conjunction with physical problems. Whilst he said that he considered the care to be very good and that the staff appeared emotionally-attached to their clients he said that, nonetheless, it was very regimented, although he did not see what other approach could have been taken, given that so many of the clients had problems. When I enquired about the ways in which the regimentation manifested, Jim reconsidered his initial comment and revised it slightly. He considered that, although some of the care was routine, such as the administration of enemas to clients, it was nonetheless effective in ensuring that clients did not experience problems and that the actual attitude of the staff towards the clients was not regimented (Interview 15:p ll).

Staff motivation and intention

This remark of Jim's also highlights the importance placed by students upon the motives and intentions of staff in their delivery of care. Jim's initial comment, that the care was perhaps rather regimented, ie orientated towards the accomplishment of discrete tasks, was subsequently revised following consideration of the attitude of the staff towards their clients (which was positive). Care which was less than ideal, but which was carried out by staff who had little preparation for practice, or whose ability to implement good practice was constrained by, for example, inadequate staffing levels, was not subject to the same level of criticism as poor quality care by qualified staff, or by staff whose intention towards patients appeared less than beneficent.

Differentiations were also made by students between care which they deemed to be 'bad', such as verbally or, in some instances, physically abusing clients and care which was unsatisfactory, but arose as a result of staff failing to think through the implications of their actions. One example of this was Jane's description, quoted earlier, of the auxiliary who shaved a client who would have been capable of doing so for himself unaided and whose return to independence was indeed predicated upon being able to accomplish self-care. Jane pointed out that she did not consider this to be 'bad' care, as it did not involve malice on the part of the auxiliary. The *intention*, in relation to care delivery was, then, deemed important by the students, independent of the end result.

That organisational constraints might remove moral culpability for care standards was earlier discussed, in Jim's comment that, when bed occupancy levels are 140%, it is impossible to speak in terms of 'good' or 'bad' care, as the only means of coping in such circumstances is by crisis management.

Students also differentiated between care which was unsatisfactory in terms of physical or verbal abuse or neglect and that which was unsatisfactory due to misuse of, or a refusal to use, mechanical devices, such as hoists and slings, in order to move and handle clients safely and effectively. Whilst the latter was considered unacceptable (and the students either declined to participate in such instances, or were reluctant to do so), it was clearly regarded as being of a

different order to behaviours which had, in their view, the intention to harm the client, or at least a failure to intend their benefit.

It was noted in the section that related to the nature of nursing work, that students viewed nursing as more than 'just a job', but it is equally important to note that this did not extend to an idealistic notion of tireless dedication. It is perhaps appropriate at this point to note that, for example, Jane's commitment to remaining at work beyond her stated hours in order to ensure that the care provision was satisfactory in her community placement, had limitations. She at no time indicated that poor staffing levels were acceptable. In her final interview, when talking about holistic care she said that:

> Jane:
> ...I'm not talking about pushing yourself [ie beyond reasonable limits] and I don't think we should push ourselves in nursing because that's not getting rid of the problem that you've not got enough [pause] members of staff, but at the same time there's patients on the ward who require [pause] input, so there's that balance between trying to, trying to achieve the best that's possible...
> (Interview 27:p 12)

Similarly, Sheila spoke about one member of staff who regularly worked longer than her shifts, as follows:

> ...I just can't get over her, [ie the staff nurse] you know?...I think you can show dedication within your eight hour shift, you know? I don't think you should have to stay over, for hours on end, to show how dedicated you are, you know?...she was responsible for seeing that the early shift was managed, but it was the folk on the late shift who should be worrying about how short-staffed they are, not her, you know? That, you know, she should be able to walk away and say, right, you know, the late shift is responsible for the late shift...I'll be responsible again when I come in the next day...
> (Interview 25:p 9)

Sheila clearly considered that such behaviour was inappropriate and did not improve the quality of care due to the risk of staff burnout. She also identified that such 'coping' behaviour (Davies 1992, 1995b) did not address the underlying problem of short-staffing and was one which should be addressed by management. She felt that, for the individual practitioner, boundaries required to be established between work and activities outwith work settings. The member of staff's

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inability to achieve this was something that, in Sheila's view, should be investigated by her manager, rather than allowed to continue, let alone be condoned (Interview 25:p 10).

Summary: Quality of Care

In summary, it can be seen that, whilst students identified specific behaviours which predisposed towards 'good' care or, conversely, interfered with its delivery, these can be subsumed under broader conceptual headings which entailed that perception of the client 'in context' emerged as being the core category. This involved treatment of clients as individuals, but it is of note that students seldom used any philosophical ethical principles per se in support of their arguments (although input in relation to these had been provided within the university setting). They did however, use the term 'holistic' quite frequently when discussing individualisation of care and the need to view the client as more than a series of health care deficits which required to be cured.

Subsumed under this description was the need for the nurse to spend time with the client, in order to foster a two-way communication process. Technical and theoretical knowledge was valued, and competence was closely linked with the nurse's acknowledgement that the substantive elements of practice should be subject to change in the light of new findings (students did not refer to research, or to the concept of evidence-based practice, despite these being 'buzz' words within health care, but the concepts which underpin these were evident in their accounts). This acknowledgement required to be accompanied by a willingness to update and to accept that, in some instances, students could provide an active contribution to this discussion. Reflection in, and upon, practice was seen as being integral part of the foregoing process and was aided by inter-occupational discussion and co-operation.

As was identified earlier in this section, the students did not appear to have a 'rose-tinted' view of the care which was achievable and, particularly in their later interviews, demonstrated an increasingly acute awareness of the ability of the organisational framework to facilitate, or inhibit, care provision. Whilst they emphasised the importance of client autonomy in decision-making, this was weighed against the problems that could present in instances in which clients lacked insight into the possible consequences of their actions, or inactions. They

also weighed up the effects of granting autonomy to one person within a care setting against the potential, or actual, effects which doing so might have upon other clients.

The qualities which the students regarded as constituting 'good care' were not those which could only be found in a 'supernurse' but, rather, comprised a perspective which placed the client, as an individual, at the centre of the care provision, whilst being mindful that the organisational framework was designed to meet the needs of an entire population and that this could create tensions in care delivery. Very firmly linked in the students' minds with good care was the necessity of nurses to provide it as a 'hands-on', integral part of their job and not at a distance. An impatience with what the students regarded as an over-emphasis upon paperwork was linked with their view of nursing as being primarily concerned with direct care, as was the tendency of some registered staff to concentrate on the aspects of their role which were the technologically more complex and which were thus accorded higher status by some practitioners.

Summary: presentation and discussion of findings

Within Chapter Four the findings from my study have been described and discussed. The students' conceptualisation of the nature of nursing work provided a prerequisite for exploration of their perceptions of care practices and processes of moral reasoning. Some of the students' perceptions conflict with the philosophy underpinning nursing curricula within the UK, most notably in the students'emphasis upon caring for those who have a health care *deficit* and their perception of health promotion in order to prevent *recurrence* of a health problem, as opposed to constituting an activity *in itself*. The focus of curricula within the initial stages of the diploma programme is upon caring 'for health' and, throughout programmes, is upon the role of nurses as health promoters and health educators, whose role is *prevention* of health care problems.

Whilst analysis of the data from each of the occasions on which the students were interviewed yielded a number of categories, including one which was central, the *core* category and *basic social process* from the study *overall* is that of *providing care in context*. All other categories relate to this, but are subsumed by it and, *in itself*, it provides an explanation for most of the data within my study.

Chapter Five provides a synthesis of my study, situates the findings in relation to the literature and focuses on the contribution of the thesis to knowledge. Some implications of the findings for practice are suggested.

Chapter Five

Discussion

Introduction

The purpose of this chapter is to provide a synthesis of my study, to situate its findings in relation to the literature and to focus on the contribution that the thesis makes to knowledge. Some implications of the findings for practice will be suggested.

The overall aim of the thesis has been the exploration of two inter-related aspects of the experience of student nurses, ie the students' perceptions of the care practices encountered during their placement experiences and, concomitantly, their processes of moral reasoning. As was identified within Chapter Two, there are few studies that address student nurses' perceptions of client care and thus a qualititative study, using a grounded theory approach, was considered appropriate.

The nature of the study

Data were obtained by means of in-depth individual interviews with the same core[1] group of nursing students on four occasions within their three year diploma programme. Whilst the rationale for selection of initial participants was *purposive*, the subsequent driving force was *theoretical* sampling, ie selection of data sources based upon theory generated by analysis of existing data, with the purpose of pursuing theory development.

As data collection progressed, it became clear that the same group of students would be participants throughout and the study thus became longitudinal. This, in itself, constitutes a contribution of the thesis to knowledge, as the longitudinal nature of the study enabled an in-depth exploration of the changes and constancies in the perceptions of a group of student nurses *over time*. This differs from other

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[1] A total of ten students participated in the study, three of whom were interviewed on one occasion. Seven students formed the group who were interviewed on four occasions.

qualitative studies within broadly similar areas to my own which have been cross-sectional or have used once-only interviews with students who are at various stages within their programme.

Symbolic Interactionism, Goffman's *Frame Analysis* and Giddens' *Structuration Theory*

As noted in Chapter Three, the philosophical underpinning of a grounded theory approach is symbolic interactionism (Mead 1934, 1964, Blumer 1969). Symbolic interactionism proposes that individuals act towards the objects/people that they encounter in accordance with the meaning that these hold for them. This meaning is learned and developed through the processes of social interaction. Subsequent encounters are processed, interpreted, reviewed and modified throughout life and individuals are thus perceived as being *active* participants in creating meaning in any given situation. Studies using this approach observe behaviours and analyse their symbolic meaning. It may be argued that interactionism over-emphasises individual agency, with limited recognition of the structures within which individuals are required to operate. In presentation of the findings from my study, whilst there was a focus upon the *interactions* of the participants, the students made overt and implicit reference to the *structures* within which interaction is situated. It was, then, necessary to provide an active acknowledgement within my account of both agency and structure.

Goffman's (1974) frame analysis was used to examine the structures within which the students operated. Goffman suggests that 'frames' provide a cultural resource for individuals and permit shared understanding of social situations. They assist identification of behaviours which are mandatory, desirable, acceptable, unacceptable and taboo within a specified setting and also help individuals to situate one frame in relation to others. Most individuals operate within a number of different frames.

A frame analysis made it clear that the students operated within a variety of structures, some of which were mutually helpful, others conflicting and some of which provided a source of support and concomitant tension. The university 'frame', for example, differed in a number of respects from that which operated within practice placements. Conflict could, however, result from a mis-match

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between theory acquired within the university frame and the students' experiences of practice within the placement frame. Frame analysis assisted identification of potential, and actual, areas of support or tension for students, both within one frame and between the exacting requirements of differing frames.

As explained within Chapter Three, the work of Giddens was used to aid analysis of the students' accounts. Giddens' (1984) proposes that neither interactionism nor structuralism are, in themselves, sufficient as explanations of human behaviour. He argues that his concept of structuration accounts for both individual agency *and* structure, although it has been argued that he over-emphasises the former, in his consideration that it is only under extreme circumstances (for example physical captivity) that individuals are deprived of agency.

It is, of course, problematic to differentiate clearly between individual agency and structural effects. Whilst the former is affected by the latter it is also the case that the success of structures is determined by those who operate within them. Whilst power is apparently held by those in charge of the structures, this may be contested by individuals who are, ostensibly, subordinates (cf Foucault 1980).

During the early interviews the students placed considerable emphasis upon the individual agency of those who deliver care within placement areas. Individuals, rather than the structures within which they operated, were deemed responsible for the quality of care delivery. This was of particular interest, as the students demonstrated an acute awareness of the structures which could facilitate or constrain their *own* individual agency within practice placements. It may be that they situated themselves within a student frame, which precluded individual agency, whereas they viewed staff as situated within a frame which accorded them the ability to be agentic, independent of structures. In later interviews, however, the students' accounts placed greater emphasis upon the facilitative or, more commonly, inhibitory effect that structures may exert upon the ability of the individual to provide care. These accounts also contained explicit recognition that the student, following registration, would be required to operate within this organisational framework.

The interplay between agency and structure was useful in identification of, and explanation for, the changes and constancies in the students' accounts over time.

The students' descriptions of their experiences in placement areas related well, in some respects, to Goffman's conceptualisation of frames, although frames may create a rather more static impression than is desired. Interviewing tended to reinforce this notion of a 'snapshot', as the interviews were pre-arranged, for the students' convenience, to take place during their term in university following practice placement experiences. It is important to note Perry's (1981) argument that data collection methods and analysis may impose an artificial notion of 'stages', whereas development is in reality a continual state of transition. Another strength of a longitudinal study lies in its potential to yield in-depth data and analysis to an extent that is impossible to achieve by means of single interviews or a cross-sectional study. Constant comparison of data from the same individual on different occasions provided the opportunity to explore the changes and constancies in their perceptions over time and additionally enabled comparison of the participants' collective accounts.

Data Analysis and Category Identification

Analysis of data from the four occasions on which students were interviewed identified major categories, as follows:

- *finding their way* (following their second placement)
- *gaining experience and confidence* (half way through their programme)
- *partnerships in care* (at the beginning of year three)
- *prepared for practice* (subsequent to their final practice placement)

As detailed within Chapter Three, the constant comparison of data was ongoing throughout the study. Upon completion of data collection, subsequent to the students' final practice placement, the data accumulated during the entirety of the study was once again examined and analysed. This revealed that, whilst the importance of *context* was discussed in the greatest detail by the students within the final interview, it was *implicit*, as well as *increasingly explicit* over time, within students' accounts during earlier interviews. The students' descriptions of what they deemed to be good care were those in which it was clear from their account that the individual patient in her/his unique context had received active acknowledgement and, conversely, care which was of poor quality was that in which this was not achieved. Thus, whilst one major category was identified from

each set of interviews, and would have been deemed the core category had the interviews been carried out on that occasion only, the longitudinal nature of the study permitted identification of one *overall* category, to which all others in the study related and which was explanatory of most of the data within the study. This core category, and basic social process, is *providing care in context*.

Providing care in context

As stated above, constant comparison of data within and across all the interviews, yielded one core category, and basic social process, which may be summed up in the concept of *providing care in context*. Recognition and active acknowledgement of contextual issues are deemed, by the students in my study, to be prerequisites for the delivery of good quality care and provide the major process within which their moral reasoning and action are embedded. On commencement of their programme, students' accounts contained a greater degree of abstraction, and reference to principles, than they did by its completion. In the final interview, in their discussion of substantive situations, students provided a thoughtful explication of the processes involved in their determination of what counts as quality care and of the problems attendant upon making generalisations in the abstract.

'Boundaries' to contextual considerations were identified in Chapter 4: these comprise elements of practice which would, within any situation, be regarded by students as unacceptable. They include, for example, shouting at patients, the exception to this being the unit described by Alan, in which the focus of care was upon the gradual reintegration of clients into the community from the state hospital. The programme included making clients aware that shouting at people, or treating them without respect, would attract a negative response from society. Thus, if a client shouted at a nurse, the nurse was permitted to shout back. This arrangement had been agreed with clients prior to commencement of their rehabilitation programme and their *informed consent* confirmed the acceptability of this practice to the student. Under no other circumstance was verbal denigration of clients or their physical abuse considered acceptable, irrespective of any other considerations. Whilst students might acknowledge, for example, that the staff involved in such practices were under pressure due to under-staffing, job insecurity, or domestic difficulties, such behaviour was deemed inexcusable.

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The over-riding importance of context is demonstrated by both positive and negative examples of care provision recounted by the students. Situations and incidents identified as positive are those in which care is individualised, to allow for the specific needs of an individual and/or their carer(s), whereas those regarded as negative are those in which the specifics of context have been unacknowledged, or actively ignored. Whilst issues of client individuality were discussed by students within the first interview, the concept of providing care *in context* is one that attained maturity over time. Within the early interviews, provision of what might be termed holistic care was spoken of in relative *abstraction*, but by the time of the final interview students provided thoughtful, in-depth, *substantive* accounts of the centrality of context to care provision.

The existence of 'boundaries' to context do not, however, weaken the analysis that *care in context* emerged as the core category within the study. When students described incidents in which they considered that abuse, verbal or physical, had occurred, they were emphatic that these were unacceptable, irrespective of the substantive situation within which they occurred. These 'boundaries', however, exist within the context of care provision for individuals who are physically and/or mentally vulnerable. For the students, care provision constitutes a context which precludes such practices, under any circumstance, by those who hold positions of trust and power.

It is appropriate to make clear, at this juncture, that the centrality of providing care in context might have emerged from interviewing the students as third year participants within a cross-sectional study, or one in which participants close to completion of their programme were interviewed on one occasion only. It would not, however, have been possible to arrive at the conclusion that *providing care in context* was a core category and basic social process that had emerged over time. The data from earlier interviews within my study yielded rather different findings. Had the data analysis from the third interviews, for example, been taken in isolation, the core category that emerged would have been *partnerships in care*. It was the comparison of accounts within and across the study as a whole that enabled recognition that, whilst *partnerships in care* was *one* category, it was overarched by *providing care in context*. The reason why partnerships in care provision were accorded such importance was, ultimately, because they enabled provision of care in context.

Within practice placement settings the students considered that acquisition of the 'wide picture', a prerequisite for providing care in context, was enabled by a variety of factors. One was increased accumulation of nursing experience, with concomitant acquisition of competence and confidence within practice placement settings. Another, closely connected to the first, was exposure to, and interaction with, the perspectives of others, both care providers and care recipients.

It is arguable that the foregoing are processes that cannot be condensed and which require time, in order to come to fruition. However, some students considered that the information necessary in order to access the 'wide picture' was limited until they acquired senior student status. In the latter stages of the students' programme, placement allocations are of longer duration and this perhaps contributes to students' ability to gain greater access to information. Given the reality of short placement allocations within the early stages of the students' programme, the study's findings indicate that designating students to provide care for a limited number of patients might enable their acquisition of a greater amount, and quality, of contextual information. This might then facilitate, from an early stage, an ability to provide care in context, or at least develop an awareness of its importance in the provision of good quality care. The concept of holistic care provision is emphasised within the university frame as being of importance in care delivery, but when students are allocated for short periods to placement areas in which there are large numbers of patients this may be an impossibility, especially in areas in which patient turnover is rapid.

The findings of my study demonstrate that recognition of the importance of providing care in context, and the ability to provide it, develops over time and is closely linked to provision of opportunities to access information about clients. This information requires to be *specific* to the individual, taking into account their substantive circumstances and the relationship of these to the wider context, ie the structures within which care provision is situated. Whilst my study explores the perceptions of student nurses, it is possible to examine these concepts in relation to other occupations with a similar focus upon health and social welfare.

The nature of nursing work

The first section of Chapter Four described and discussed the students' conception of nursing work, as this provides the foundation for their perceptions of care practices. For the students within my study the following were the criteria for *nursing* work:

- those cared for require to have some form of health care deficit (ie this precludes the care of healthy children in a nursery)
- the care provided must relate directly to the health care deficit (and cannot, for example, have a custodial, rather than therapeutic, purpose)
- the carer requires to have a formal preparation for practice
- the carer is accorded a public/occupational role in relation to the person being cared for and concomitant financial remuneration in recognition of this
- hierarchical frameworks inhibit nursing work: those who move upwards within the hierarchy acquire an administrative, as opposed to client, focus.

These findings are important, as they run counter, in some respects, to the philosophy underpinning nursing curricula. The finding that the students within my study perceived that they entered nursing in order to care for those who have a health deficit does not concur with the official ideology and educational policy within their preparation for practice. Current nursing programmes place considerable initial emphasis upon the importance of caring 'for health' and provide some practice placement experiences within which students care for healthy individuals (for example children in nursery settings). Such placements were not valued by the students, as they were considered irrelevant to their future practice as registered nurses.

The students' perception of health promotion was that, for the most part, it comprises an activity that is carried out *subsequent* to an episode of ill-health, which has necessitated nursing intervention, rather than as a pre-emptive strike, or as a central component of their job. Again, this runs contrary to the curricula within nursing programmes, which place considerable emphasis upon the importance of health promotion, per se.

Whilst the expectations of entrants into *any* occupation may not clearly correlate to their subsequent experiences within the realities of practice, such mis-matches

may cause disquiet, denial, or disillusionment. For the students in my study, caring for healthy children was not valued as a preparation for nursing practice. Whilst the students, by the time of recounting their nursery placement experience, viewed it as 'history' (albeit with residual resentment), their perception of it as unrelated to nursing work persists and this, then, is likely to be an attitude conveyed to subsequent neophytes. Similarly, the students' view that health promotion is not really part of mainstream *nursing*, but comprises what is almost a fringe interest (despite theoretical input to the contrary), demonstrates the resilience of 'traditional' images of nursing.[2]

The students' pragmatism about the quantity and quality of care that they consider necessary and, indeed, desirable, is notable. As discussed within the literature review in Chapter Two, none of the students in my study identified the level of intimacy advocated by Watson (1979, 1988, 1990) as being appropriate, even if it were attainable, which is unlikely, given the organisational constraints which pertain in most practice placement settings. The work of Watson and a number of other nursing theorists has been influential, in its focus upon affect and in its relative lack of acknowledgement of the importance of psychomotor skills in nursing practice. It is thus of interest that, whilst the core category and basic social process which emerged from my study was that of providing care in context, the students' conceptualisation of nursing is one in which *emotional engagement with*, rather than *emotional attachment to*, patients and clients is perceived as appropriate.

The students considered technical competence in *relevant* psychomotor skills to be an integral component of providing care in context and valued its acquisition, although certainly not at the expense of their attainment of psycho-social skills. They felt able to focus upon the latter, once they had acquired competence in the former. Initially, when the students participated in care, their attention was concentrated upon the accomplishment of quite complex psychomotor skills (for example administration of injections, recording of blood pressure) and this impeded their ability to perceive the patient 'in context'. Psychomotor skill attainment, then, is not only an end in itself, but also provides a means to increasing students' awareness of the 'wide picture'.

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[2]Media representations of nursing work, identified within Chapter Four, may be powerful in maintaining these 'traditional' stereotypes.

The students' moral reasoning

I argued earlier that nursing is a moral enterprise, a view supported by Downie and Calman (1994) and Thompson et al (2000), and that it is thus impossible to compartmentalise its practice into the morally-significant and the morally-neutral. Whilst nursing practice contains elements which are technical, rather than affective, it would be a narrowly-focused conception of morality that would deny that, given the *context* within which such technical tasks occur, they are devoid of a moral dimension. Technical competence, or its lack, may have a profound effect upon the patient's welfare and I have argued that *moral* reasoning and *moral* judgments are thus all-pervasive within nursing. *All* decisions made, and *all* actions taken, in relation to a patient's care are inseparable from their beneficial, or deleterious, outcome(s) for that individual. Evaluation of psychomotor skills cannot be restricted to an assessment of technical competence in a vacuum, as compartmentalising judgements into those which are 'morally-significant' and those which are 'morally-innocuous' is rendered impossible by the impact of all nursing practice upon the patient. The argument that nursing is per se a moral enterprise and that there is thus no element of its practice which is morally-neutral, necessitates that judgements made in relation to the quality of nursing care are, by definition, *moral* judgements.

The moral development theories of Kohlberg and Gilligan were examined at some length within Chapter Two, the rationale being, firstly, the dominant status of their work vis à vis nursing curricula and, secondly, the fact that much of the research relating to the moral reasoning and decision-making of nurses is based upon the work of one or both.

One major finding from my study is that the processes used by the students in their deliberations about the quality of care do not equate, in any readily-discernible or clear-cut way, with the perspectives of either Kohlberg or Gilligan (although they have a greater affinity with the latter than the former). This is of particular interest because, as stated above, much of the literature related to the moral reasoning and judgements of nurses is based upon their work. It is also of interest in view of the fact that students receive lecture input about the theories of Kohlberg and Gilligan within the social and behavioural science component of their programme. Whilst it is probably unsurprising that the students who were interviewed did not identify either Kohlberg or Gilligan by name, it is notable that the theory input they

received about psychological development and moral reasoning was not alluded to, let alone explicated. Neither Kohlberg's theory, in which movement from contextual reasoning to universal principles signifies moral 'progress', nor Gilligan's emphasis upon an ethic of care to the virtual exclusion of other considerations, were identified by the students as being relevant to the realities of nursing practice. The data from my study are, then, of interest not only in relation to the categories that they generated, but also in relation to what was *absent* from the students' accounts.

The findings from my study are of importance when placed alongside those which were described and discussed within the literature review and which explore student nurses' moral reasoning from a 'justice' or 'care' perspective. My findings suggest that these may be inappropriate starting points from which to develop questionnaires and interview agendas, or as templates for data analysis. Findings from studies predicated upon a justice or care perspective may be misleading, or at least incomplete, as insufficient credit will be accorded to the sophistication and complexity of participants' *processes* of moral reasoning.

Had the students in my study been interviewed in year one of their programme and again in year three, using Kohlberg's classification, then they would probably have attained a 'higher' score at time one than time two. The students made reference to abstract principles to a greater extent during the early stages of their programme than they did by its completion. By the end of the students' programme, their conceptualisations of good and bad practice were discussed in a more contextualised manner than they were at its commencement. Moral judgements and identification of principles became situated in substantive situations, as opposed to hypothetical abstractions. For the students in my study, exposure to the realities of care rendered resorting to abstract universal moral principles problematic, as an increasing awareness of the contexts in which individuals are required to operate appeared to diminish their propensity to generalise. As Kohlberg's account of moral reasoning remains influential, and accords high value to an ability to generalise in abstraction, rating the students by such means precludes acknowledgement of their moral accomplishment. This has implications for academic evaluation of student nurses' moral reasoning.

I have argued earlier within the thesis that moral reasoning based upon abstract principles is facilitated by a real or symbolic distance from substantive situations

and, indeed, may only be possible in such circumstances. The nature of nursing work, with its direct, intimate and sustained contact between nurse and patient, does not facilitate, and may indeed preclude, the possibility of such distance and detachment. It is possible, on the other hand, that the work of medical staff, in which encounters with patients are usually fleeting and intermittent, and which frequently occur in a formalised, ceremonial setting, permit formulation of abstract principles, at least to some extent. It is even more possible that individuals who have no direct involvement in patient care, for example hospital managers and policy makers, may be able to adopt such an approach. The individuals in charge of health care policy are those whose reasoning processes constitute the criteria against which the approaches of others are measured. Those who are unable, or unwilling, to adopt, or at least accept, these processes and judgements may be viewed as deviant, or as less competent moral agents.

It can be seen that, if Kohlberg's categorisation of levels of moral reasoning is applied to the findings from my study, the students' emphasis upon contextual issues will assign their level of moral reasoning to a lower status than that accorded to 'principled' thinkers. It is, of course, possible to argue that the students' emphasis upon context does, in itself, constitute a universalisable principle, but it seems unlikely that Kohlberg, or adherents to his theory, would concur with this, given their emphasis upon an abstract conception of justice as the universal principle.

The data generated from the students in my study indicate that the moral rationale they provide about care provision increases in complexity over time, whilst their ability to generalise decreases. This perspective appears closer to that of Gilligan in some respects, but the students' accounts do not emphasise *care* exclusively and the data are not suggestive of an *ethic* of care, per se. Rather, the students' moral judgements, and the processes of moral reasoning upon which these are founded, appear to bear a closer relationship to the writers (Tappan, Hekman, Manning, Pierce) whose work suggests a more complex, less clear-cut, moral foundation for practice. The data from the fourth interview with the students demonstrate an increasingly sophisticated view of 'context'. It would seem important that this be taken into account in any research enterprise that attempts to map moral reasoning processes.

Acknowledgement of the students' processes of moral reasoning indicates that the teaching of ethics and morals as *abstract* theory may be inappropriate. It is, then, important to relate theoretical concepts to substantive situations, with consequent sensitivity to the specific context in which these are situated. The use, similarly, of truncated scenarios is inappropriate, given the students' quest for access to the 'wide picture', in order to make decisions. The use of lengthier scenarios, which provide greater contextual information, would be more appropriate. Even more relevant would be the use of the students' own experiences of morally-problematic situations acquired within practice placement settings, as they can more readily supply the contextual information required. As presentation and discussion of such cases will be more detailed, and consequently lengthier, than that which results from pre-selected, truncated, scenarios, it would be an appropriate method for use only within small group settings. The small group is also necessary in order to promote an atmosphere which facilitates in-depth discussion. Clearly, issues of confidentiality require to be acknowledged and addressed within such an approach and the maintenance of client and placement anonymity may be problematic, given the students' possible knowledge of one another's placement allocations. Nonetheless, reinforcement to students of the need to ensure that disclosure of information is not traceable to a particular individual and that discussion of issues should be confined to the small-group setting, could be provided. Students are already familiar with the establishment and use of 'ground rules' in relation to confidentiality within the tutorial sessions during which they reflect upon their practice. At present, the students' own experiences are used to a limited extent within the programme, but the expansion of approaches which use the students' perspective as a foundation for learning via discussion would seem desirable. This would enable in-depth exploration of substantive, rather than hypothetical, issues and facilitate the contextualised decision-making that the students deem necessary in order to provide high quality care. This is also relevant to students within occupations with a similar client focus to nursing.

Conclusion

The overall aim of this thesis has been to explore the perceptions of student nurses, in relation to the patient/client care that they encountered during their practice placements. The students' conceptualisation of the nature of *nursing* work provided the foundation for identification and exploration of the factors and processes, by means of which they deemed the quality of care provision to be satisfactory or otherwise. The study has contributed to existing knowledge, both in terms of the research method used and the substantive findings generated.

The longitudinal nature of the study provided an opportunity to explore, in depth and over time, the changes and constancies in the students' accounts. This generated a different perspective on the students' moral reasoning than studies using single interviews or a cross-sectional design.

Analysis of data from the four sets of interviews yielded one major category from each. Comparison of the data within and across all interviews identified that the major categories from the earlier interviews (*finding their way*, *gaining experience*, *partnerships in care*) provided the foundation for the main category from the fourth set of interviews (*prepared for practice*). *All* of these major categories were subsumed by that of *providing care in context* which, upon completion of their programme, was the core category and basic social process by means of which the students viewed care provision as being satisfactory, or otherwise.

The nature of nursing work differs, in the students' perspective, from official ideology and policy in a number of salient ways, most notably in their focus upon health care deficits and the low profile accorded to health promotion per se. It is also of interest that, whilst the students considered *individualised* care to be a prerequisite for quality, the valorisation of affective skills proposed by some authors (for example Watson 1988, 1990) was not articulated by the students.

In relation to the students' moral reasoning, the findings reveal processes that are more sophisticated and complex than the theories of Kohlberg or Gilligan suggest. If such theories continue to be used to underpin research, then the students' reasoning processes will not receive due credit. The account that I have presented is discursive, but such an approach is necessitated by the territory that the study

explores. Neatly-boxed findings, whilst appealing in some respects, are misleading in their simplicity and do not allow sufficient recognition of the complexity of the students' explication of their experiences. The findings from my study indicate that a prerequisite for any such research enterprise is to use methods which facilitate, rather than constrict, the students' opportunity to explain their own experiences, perceptions and perspectives.

BIBLIOGRAPHY

Anderson C (1995). *Learning to Discuss, Discussing to Learn: a study of tutorial groups in a faculty of social sciences.* University of Edinburgh: Unpublished Ph.D. Thesis.

Artinian B A (1988). Qualitative modes of inquiry. *Western Journal of Nursing Research,* 10, 2, 138-149.

Astrom G, Jansson L, Norberg A, Hallberg I R (1993). Experienced nurses' narratives of their being in ethically difficult situations. *Cancer Nursing* 16, 3, 179-187.

Atkinson P (1995). Some perils of paradigms. *Qualitative Health Research,* 5, 1, 117-124.

Atkinson P (1997). Narrative turn or blind alley? *Qualitative Health Research,* 7, 3, 325-344.

Atkinson P (1999). Review essay: voiced and unvoiced. *Sociology,* 33, 1, 191-197.

Atkinson P, Delamont S (1990). Professions and powerlessness: female marginality in the learned occupations. *Sociological Review,* 38, 90-110.

Baier A (1985). *Postures of the Mind: essays on mind and morals.* Minneapolis: University of Minnesota Press.

Baker C, Wuest J, Stern P N (1992). Method slurring: the grounded theory/phenomenology example. *Journal of Advanced Nursing,* 17, 1355-1360.

Bar-Yam M, Kohlberg L, Naame A (1980). Moral reasoning of students in different cultural, social, and educational settings. *American Journal of Education,* 88, 345-362.

Beck C T (1999). Quantitative measurement of caring. *Journal of Advanced Nursing,* 30, 1, 24-32.

Benner P, Wrubel J (1989). *The Primacy of Caring: stress and coping in health and illness.* New York: Addison-Wesley.

Blatt M, Kohlberg L (1975). The effects of classroom moral discussion upon children's level of moral judgment. *Journal of Moral Education* 4, 129-161.

Blum L (1986). Iris Murdoch and the domain of the moral. *Philosophical Studies,* 50, 343-367.

Blum L (1988). Gilligan and Kohlberg: implications for moral theory. *Ethics*, 98, 3, 472-491.

Blumer H (1969). *Symbolic Interactionism: perspective and method*. Englewood Cliffs, NJ: Prentice-Hall.

Brink P J (1987). On reliability and validity in qualitative research. *Western Journal of Nursing Research*, 9, 2, 157-159.

Bruner J (1986). *Actual Minds, Possible Worlds*. Cambridge, Mass.: Harvard University Press.

Chenitz W C, Swanson J M (Eds) (1986). *From Practice to Grounded Theory - qualitative Research in Nursing*. Menlo Park, California: Addison-Wesley Publishing Co.

Chipman Y (1991). Caring: its meaning and place in the practice of nursing. *Journal of Nursing Education*, 30, 4, 171-175.

Chodorow N (1978). *The Reproduction of Mothering: psychoanalysis and the sociology of gender*. London: University of California Press.

Coffey A (1999). *The Ethnographic Self: fieldwork and the representation of identity*. London: Sage.

Coffey A, Atkinson P (1996). *Making Sense of Qualitative Data: complementary research strategies*. Thousand Oaks, California: Sage.

Colliere M F (1986). Invisible care and invisible women as health care providers. *International Journal of Nursing Studies*, 23, 2, 95-112.

Corley M C, Selig P M (1992). Nurse [sic] moral reasoning using the Nursing Dilemma Test. *Western Journal of Nursing Research*, 14, 3, 380-388.

Craib I (1992). *Anthony Giddens*. London: Routledge.

Crisham P (1981). Measuring moral judgement in nursing dilemmas. *Nursing Research*, 30, 2, 104-110.

Cronin S N, Harrison B (1988). Importance of nurse caring behaviors as perceived by patients after myocardial infarction. *Heart and Lung*, 17, 4, 374-380.

Davies C (1992). Gender, history and management style in nursing: towards a theoretical synthesis. In Savage M, Witz A (Eds) *Gender and Bureaucracy*. Oxford: Blackwell/The Sociological Review.

Davies C (1995a). Competence versus care? Gender and caring work revisited. *Acta Sociologica*, 38, 17-31.

Davies C (1995b). *Gender and the Professional Predicament in Nursing*. Buckingham: Open University Press.

Davis K (1992). Toward a feminist rhetoric: the Gilligan debate revisited. *Women's Studies International Forum* 15, 2, 219-231.

Denzin N K, Lincoln Y S (1994). *Handbook of Qualitative Research*. London: Sage.

Dierckx de Casterle B, Janssen P J, Grypdonck M (1996). The relationship between education and ethical behavior of nursing students. *Western Journal of Nursing Research*, 18, 3, 330-350.

Dierckx de Casterle B, Grypdonck M, Vuylsteke-Wauters M, Janssen P J (1997). Nursing students' responses to ethical dilemmas in nursing practice. *Nursing Ethics*, 4, 1, 12-28.

Downie R S, Calman K C (2nd ed) (1994). *Healthy Respect: ethics in health care*. Oxford: Oxford University Press.

Duckett L, Rowan-Boyer M, Ryden M B, Crisham P, Savik K, Rest R J (1992). Challenging misperceptions about nurses' moral reasoning. *Nursing Research*, 41, 6, 324-331.

Duke S, Copp G (1992). Hidden nursing. *Nursing Times* 88, 17, 40-42.

Dunlop M J (1986). Is a science of caring possible? *Journal of Advanced Nursing*, 11, 661-670.

Emden C (1997). A conversation with Margarete Sandelowski and Philip Darbyshire: issues in qualitative inquiry. *Nursing Inquiry*, 4, 138-141.

Finch J, Groves D (Eds) (1980). *A Labour of Love: women, work and caring*. London: Routledge and Kegan Paul.

Foucault M (1980). *Power/Knowledge: selected interviews and other writings 1972-1977*. New York: Pantheon Books.

Freeman M (1993). *Rewriting the Self: history, memory, narrative*. London: Routledge.

Frye M (1991). A response to *Lesbian Ethics*: why ethics?. In Card C (Ed). *Feminist Ethics*. Lawrence: University of Kansas Press.

Gamarnikow E (1978). Sexual division of labour: the case of nursing. In Kuhn A, Wolpe A (Eds). *Feminism and Materialism*. London: Routledge and Kegan Paul.

Gaut D A (1983). Development of a theoretically adequate description of caring. *Western Journal of Nursing Research*, 5, 4, 313-324.

Giddens A (1984). *The Constitution of Society*. Oxford: Polity.

Gilligan C (1982). *In a Different Voice: psychological theory and women's development*. London: Harvard University Press.

Gilligan C (2nd ed) (1993). *In a different voice: psychological theory and women's development*. Cambridge, Mass: Harvard University Press.

Glaser BG (1978). *Theoretical Sensitivity: advances in the methodology of grounded theory*. Mill Valley, California: The Sociology Press.

Glaser B G (1992). *Basics of Grounded Theory: emergence versus forcing*. Mill Valley, California: The Sociology Press.

Glaser B G, Strauss A L (1967). *The Discovery of Grounded Theory: strategies for qualitative research*. New York: Aldine de Gruyter.

Goffman E (1974). *Frame Analysis: an essay on the organisation of experience*. New York: Harper and Row.

Gonos G (1977). "Situation" versus "Frame": the "Interactionist" and the "Structuralist" analyses of everyday life. *American Sociological Review*, 42, 854-867.

Graham H (1983). Caring: a labour of love. In Finch J, Groves D (Eds) *A Labour of Love: women, work and caring*. London: Routledge and Kegan Paul.

Gray M (1997). *The Professional Socialisation of Project 2000 Student Nurses: a longitudinal qualitative investigation into the effect(s) of supernumerary status and mentorship on student nurses*. University of Glasgow: Unpublished PhD Thesis.

Grundstein-Amado (1991). An integrative model of clinical ethical decision making. *Theoretical Medicine*, 12, 157-170.

Grundstein-Amado (1993). Ethical decision-making processes used by health care providers. *Journal of Advanced Nursing*, 18, 1701-1709.

Guba E G, Lincoln Y S (1989). *Fourth Generation Evaluation*. Newbury Park, California: Sage.

Hammersley M, Atkinson P (2nd ed) (1995). *Ethnography: principles in practice.* London: Routledge.

Hare R M (1981). *Moral Thinking: its levels, method and point.* Oxford: Clarendon Press.

Hekman S (1995). *Moral Voices Moral Selves: Carol Gilligan and feminist moral theory.* Cambridge: Polity Press.

Hirsch E D (1967). *Validity in Interpretation.* New Haven: Yale University Press.

Hochschild A R (1983). *The Managed Heart: commercialisation of human feeling.* Berkeley, Calif.: University of California Press.

Hoffman M L (1987). The contribution of empathy to justice and moral development. In Eisenberg N, Strayer J (Eds). *Empathy and its Development.* New York: Cambridge University Press.

Holm S (1997). *Ethical Problems in Clinical Practice: the ethical reasoning of health care professionals.* Manchester: Manchester University Press.

Holm S, Gjersoe P, Grode G, Hartling O, Ibsen K E, Marcussen H (1996). Ethical reasoning in mixed nurse-physician groups. *Journal of Medical Ethics,* 22, 68-173.

Holstein J A, Gubrium J F (1995). *The Active Interview.* Newbury Park, California: Sage.

Hugman R (1991). *Power in Caring Professions.* London: Macmillan Press.

James V (1986). *Care and Work in Nursing the Dying.* University of Aberdeen: Unpublished Ph.D. Thesis.

James N (1992a). Care, work and carework: a synthesis? in Robinson J, Gray A, Elkan R (Eds) *Policy Issues in Nursing.* Buckingham: Open University Press.

James N (1992b). Care = organisation + physical labour + emotional labour. *Sociology of Health and Illness,* 14, 4, 488-509.

Jansson L, Norberg A (1989). Ethical reasoning concerning the feeding of terminally ill cancer patients: interviews with registered nurses experienced in the care of cancer patients. *Cancer Nursing,* 12, 6, 352-358.

Joudrey R, Gough J (1999). Caring and curing revisited: student nurses' perceptions of nurses' and physicians' ethical stances. *Journal of Advanced Nursing,* 29, 5, 1154-1162.

Kaplan B (1983). A trio of trials. In Lerner R (Ed). *Developmental Psychology: historical and philosophical perspectives,* Hillsdale, New Jersey: Lawrence Eribaum.

Kelly B (1991). The professional values of English nursing undergraduates. *Journal of Advanced Nursing,* 16, 867-872.

Kelly B (1992). Professional ethics as perceived by American nursing undergraduates.
Journal of Advanced Nursing, 17, 10-15.

Kelly B (1996). Ethical hospital nursing as perceived by British and American nursing undergraduates. *Social Sciences in Health,* 2, 1, 36-53.

Kerber L K, Greeno C G, Maccoby E E, Luria Z, Stack C B, Gilligan C (1986). On *In a Different Voice:* an interdisciplinary forum. *Signs: Journal of Women in Culture and Society,* ll, 2, 304-333.

Ketefian S (1981a). Critical thinking, educational preparation, and development of moral judgment among selected groups of practicing nurses. *Nursing Research,* 30, 2, 98-103.

Ketefian S (1981b). Moral reasoning and moral behavior among selected groups of practicing nurses. *Nursing Research,* 30, 2, 171-176.

Ketefian S (1985). Professional and bureaucratic role conceptions and moral behavior among nurses. *Nursing Research,* 43, 4, 248-253.

Ketefian S (1987). A case study of theory development: moral behavior in nursing. *Advances in Nursing Science,* 9, 2,10-19.

Kitson, A (1987). A comparative analysis of lay-caring and professional (nursing) caring relationships. *International Journal of Nursing Studies,* 24, 2, 155-165.

Koch T (1994). Establishing rigour in qualitative research: the decision trail. *Journal of Advanced Nursing,* 19, 976-986.

Kohlberg L (1958). *The Development of Modes of Moral Thinking and Choice in Years Ten to Sixteen.* Chicago: PhD dissertation, University of Chicago. Cited by Kohlberg L (1981). *Essays on Moral Development: Vol I The philosophy of moral development.* San Fancisco: Harper and Row.

Kohlberg L (1969). Stage and sequence: the cognitive-development approach to socialization. In Goslin D A (Ed) *Handbook of Socialization Theory and Research.* Chicago: Rand McNally.

Kohlberg L (1976). Moral stages and moralisation: The cognitive-developmental approach. In Lickona T (Ed) *Moral Development and Behavior: theory, research and social issues.* New York: Holt, Rinehart and Winston.

Kohlberg L (1981). *Essays on Moral Development: Vol I The philosophy of moral development.* San Fancisco: Harper and Row.

Kohlberg L (1984). *Essays on Moral Development: Vol. 2 The Psychology of Moral Development.* New York: Harper and Row.

Krawczyk R M (1997). Teaching ethics: effect on moral development. *Nursing Ethics,* 4, 1, 57-65.

Kroeger-Mappes J (1994). The ethic of care vis a vis the ethic of rights: a problem for contemporary moral theory. *Hypatia,* 9, 3, 108-131.

Kuhn T (1970) (2nd ed.) *The Structure of Scientific Revolutions.* Chicago: University of Chicago Press.

Kuhse H (1997). *Caring: Nurses, women and ethics.* Blackwell: Oxford.

Kyle T (1995). The concept of caring: a review of the literature. *Journal of Advanced Nursing,* 21, 506-514.

Larson P J (1984). Important nurse caring behaviors perceived by patients with cancer. *Oncology Nursing Forum,* 11, 6, 46-50.

Larson P J (1986). Cancer nurses' perceptions of caring. *Cancer Nursing,* 9, 2, 86-91.

Lea A, Watson R (1996). Caring research and concepts: a selected review of the literature. *Journal of Clinical Nursing,* 5, 71-77.

Lea A, Watson R, Deary I J (1998). Caring in nursing: a multivariate analysis. *Journal of Advanced Nursing,* 28, 3, 662-671.

LeCompte M D, Preissle J (with Tesch R) (2nd ed.) (1993). *Ethnography and Qualitative Design in Educational Research.* San Diego: Academic Press.

Leininger M (1981a). The phenomenon of caring: importance, research questions and theoretical considerations. In Leininger M (Ed). *Caring. An Essential Human Need. Proceedings from Three National Caring Conferences.* Thorofare, NJ: Slack.

Leininger M (1981b). Cross-cultural hypothetical functions of caring and nursing care. In Leininger M (Ed). *Caring. An Essential Human Need. Proceedings of Three National Caring Conferences.* Thorofare, NJ: Slack.

Leininger M (1985). Nature, rationale, and importance of qualitative research methods in nursing. In Leininger M (Ed) *Qualitative Research Methods in Nursing.* Orlando, Florida: Grune and Strattton.

Leininger M (1988). History, issues, and trends in the discovery and uses of care in nursing. In Leininger M (Ed) *Care. Discovery and Uses in Clinical and Community Nursing.* Thorofare, New Jersey: Slack.

Leininger M (1992). Current issues, problems, and trends to advance qualitative paradigmatic research methods for the future. *Qualitative Health Research,* 2, 4, 392-415.

Lincoln Y S, Guba E G (1985). *Naturalistic Inquiry.* Beverly Hills, California: Sage.

Lindseth A, Marhaug V, Norberg A, Uden G (1994). Registered nurses' and physicians' reflections on their narratives about ethically difficult care episodes. *Journal of Advanced Nursing,* 20, 245-250.

Lofland J, Lofland L H (3rd ed) (1995). *Analyzing Social Settings: a guide to qualitative observation and analysis.* Belmont, California: Wadsworth.

McAlpine H, Kristjanson L, Poroach D (1997). Development and testing of the ethical reasoning tool (ERT): an instrument to measure the ethical reasoning of nurses. *Journal of Advanced Nursing,* 25, 1151-1161.

McCance T V, McKenna H P, Boore J R P (1997). Caring: dealing with a difficult concept. *International Journal of Nursing Studies,* 34, 4, 241-248.

Manning R (1992). *Speaking from the Heart: A feminist perspective on ethics.* Lanham, Maryland: Rowman and Littlefield.

Mead G H (1934). *Mind, Self and Society: from the standpoint of a social behaviourist.* Chicago: University of Chicago Press.

Mead G H (1964). *George Herbert Mead on Social Psychology.* Chicago: University of Chicago Press.

Melia K M (1981). *Student Nurses' Accounts of their Work and Training: a qualitative analysis.* University of Edinburgh: Unpublished Ph.D. Thesis.

Melia K M (1987). *Learning and Working: the occupational socialisation of nurses.* London: Tavistock.

Melia K M (1996). In Holloway I, Wheeler S (Eds) *Qualitative Research for Nurses.* Oxford: Blackwell.

Melia K M (2000). Personal communication. University of Edinburgh: supervision meeting.

Menzies I E P (1960). A case study in the functioning of social systems as a defence against anxiety. *Human Relations,* 13, 95-121.

Miles M B, Huberman A M (2nd ed) (1994). *Qualitative Data Analysis: an expanded sourcebook.* Thousand Oaks, California: Sage.

Millette B E (1993). Client advocacy and the moral orientation of nurses. *Western Journal of Nursing Research,* 15, 5, 607-618.

Millette B E (1994). Using Gilligan's framework to analyze nurses' stories of moral choices. *Western Journal of Nursing Research,* 16, 6, 660-674.

Minow M (1990). *Making All the Difference: inclusion, exclusion, and American Law.* Ithaca: Cornell University Press. Cited in Hekman S (1995). *Moral Voices Moral Selves: Carol Gilligan and feminist moral theory.* Cambridge: Polity Press.

Mishler E G (1990). Validation in inquiry-guided research: the role of exemplars in narrative studies. *Harvard Educational Review,* 60, 4, 415-442.

Morrison P (1989). Nursing and caring: a personal construct theory study of some nurses' self-perceptions. *Journal of Advanced Nursing,* 14, 421-426.

Morrison P (1991). The caring attitude in nursing practice: a reportory grid study of trained nurses' perceptions. *Nurse Education Today,* 11, 1, 3-12.

Morse J M (1986). Qualitative research: issues in sampling. In Chinn P L (Ed) *Nursing research methodology.* Aspen: Rockville MD.

Morse J M (revised ed.) (1991). *Qualitative Nursing Research: A contemporary dialogue.* Newbury Park, Calif.: Sage.

Morse J M (1992a). The power of induction. *Qualitative Health Research,* 2, 1, 3-6.

Morse J M (1992b). If you believe in theories... *Qualitative Health Research,* 2, 3, 259-261.

Morse J M (1993). Drowning in data. *Qualitative Health Research,* 3, 3, 267-269.

Morse J M (1995a). Exploring the theoretical basis of nursing using advanced techniques of concept analysis. *Advances in Nursing Science,* 17, 3, 31-46.

Morse J M (1995b). The significance of saturation. *Qualitative Health Research*, 5, 2, 147-149.

Morse J M (1998). Validity by committee. *Qualitative Health Research*, 8, 4, 443-445.

Morse J M (1999a). Qualitative generalizability. *Qualitative Health Research*, 9, 1, 5-6.

Morse J M (1999b). Silent debates in qualitative inquiry. *Qualitative Health Research*, 9, 2, 163-165.

Morse J M (1999c). Qualitative generalizability. *Qualitative Health Research*, 9, 1, 5-6.

Morse J M, Solberg S M, Neander W L, Bottorf J L, Johnson J L (1990). Concepts of caring and caring as a concept. *Advances in Nursing Science*, 13, 1, 1-14.

Morse J M, Mitcham C, Hupcey J E, Tason M C (1996). Criteria for concept evaluation. *Journal of Advanced Nursing*, 24, 385-390.

Morse J M, Field P A (2nd ed) (Eds) (1996). *Nursing Research - the application of qualitative approaches.* London: Chapman and Hall.

Noddings N (1984). *Caring: A feminine approach to ethics and moral education.* Berkeley, California: University of California Press.

Noddings N (1989). *Women and Evil.* Berkeley, California: University of California Press.

Noddings N (1990). Review symposium: a response. *Hypatia,* 5, 1, 120-126.

Norberg A, Uden G (1995). Gender differences in moral reasoning among physicians, registered nurses and enrolled nurses engaged in geriatric and surgical care. *Nursing Ethics* 2, 3, 233-242.

Nussbaum M (1986). *The Fragility of Goodness.* New York: Cambridge University Press.

Oberle K (1995). Measuring nurses' moral reasoning. *Nursing Ethics,* 2, 4, 303-313.

Orem D (3rd ed) (1985). *Nursing: concepts of practice.* Chevy Chase, Md: McGraw-Hill.

Parker R S (1990). Nurses' stories: the search for a relational ethic of care. *Advances in Nursing Science*, 13, 1, 31-40.

Patton M Q (2nd ed) (1990). *Qualitative evaluation and research methods.* Newbury Park, California: Sage.

Pegram A (1992). How do qualified nurses perceive care? *Journal of Clinical Nursing*, 1, 1, 48-49. Cited by Kyle T (1995). The concept of caring: a review of the literature. *Journal of Advanced Nursing*, 21, 506-514.

Perry W (1968). *Forms of Intellectual and Ethical Development in the College Years.* New York, Holt, Rinehart and Winston.

Perry W G (1981). Cognitive and ethical growth: the making of meaning. in Chickering A (Ed) *The Modern American College.* San Francisco: Jossey-Bass.

Piaget J (1948). *The Moral Judgment of the Child.* New York: Free Press. (Originally published 1932.)

Pierce S F (1990). *Health Care Professionals' Ethical Decision Making: the nature of their moral reasoning.* University of North Carolina at Chapel Hill: Unpublished Ph.D. dissertation.

Pierce S F (1997). Conceptualising the moral dynamic in health care. *Nursing Ethics*, 4, 6, 483-495.

Popay J, Rogers A, Williams G (1998). Rationale and standards for the systematic review of qualitative literature in health services research. *Qualitative Health Research*, 8, 3, 341-351.

Porter S (1993). Nursing research conventions: objectivity or obfuscation? *Journal of Advanced Nursing*, 18, 137-143.

Reed J, Procter S, Murray S (1996). A sampling strategy for qualitative research. *Nurse Researcher*, 3, 4, 52-68.

Rest J R (1973). The hierarchical nature of moral judgement. *Journal of Personality*, 41, 86-109. Cited by Kohlberg (1981). *Essays on Moral Development: Vol I The philosophy of moral development.* San Fancisco: Harper and Row.

Rest J R (1974). *Manual for Defining Issues Test: an objective test of moral judgement.* Minneapolis: University of Minnesota.

Rest J R (1976). New approaches in assessing moral judgment. In Lickona T (Ed) *Moral development and behavior: theory, research and social issues.* New York: Holt, Rinehart and Winston.

Rest J R, Barnett R, Beceau M, Deemer D (1986). *Moral Development: advances in research and theory*. New York: Praeger.

Rest J R (1993). *Guide for the Defining Issues Test*. Minneapolis, MN: Center for the Study of Ethical Development. Cited by McAlpine H, Kristjanson L, Poroach D (1997). Development and testing of the ethical reasoning tool (ERT): an instrument to measure the ethical reasoning of nurses. *Journal of Advanced Nursing*, 25, 1151-1161.

Reverby S (1987). *Ordered to Care: the dilemma of American nursing 1850-1945*. Cambridge: Cambridge University Press.

Reverby S (1994). A caring dilemma: womanhood and nursing in historical perspective. In Conrad P, Kern R (Eds) (4th ed.) *The Sociology of Health and Illness: Critical Perspectives*. New York: St Martin's Press.

Richards T, Richards L (1994). Using computers in qualitative research. In Denzin N K, Lincoln Y S (1994). *Handbook of qualitative research*. London: Sage.

Rickard M, Kuhse H, Singer P (1996). Caring and Justice: a study of two approaches to health care ethics. *Nursing Ethics*, 3, 3, 212-223.

Roach M S (1984). *Care, The Human Mode of Being: implications for nursing*. Toronto: University of Toronto.

Roach M S (1987). *The Human Act of Caring: a blueprint for health professions*. Toronto, Canada: Canadian Hospital Association.

Roach M S (1992) (revised ed.). *The Human Act of Caring: a blueprint for the health professions*. Ottawa: Canadian Hospitals Association.

Rodgers B L (1989). Concepts, analysis and the development of nursing knowledge: the evolutionary cycle. *Journal of Advanced Nursing*, 14, 330-335.

Rorty R (1989). *Contingency, Irony and Solidarity*. New York: Cambridge University Press. Cited by Hekman S (1995). *Moral Voices Moral Selves: Carol Gilligan and feminist moral theory*. Cambridge: Polity Press.

Sandelowski M (1986). The problem of rigor in qualitative research. *Advances in Nursing Science*, 8, 3, 27-37.

Sandelowski M (1993). Rigor or rigor mortis: the problem of rigor in qualitative research revisited. *Advances in Nursing Science*, 16, 2, 1-8.

Schatzman L, Strauss A L (1973). *Field Research: strategies for a natural sociology*. Englewood Cliffs, New Jersey: Prentice-Hall.

Scolari (date unlisted). *QSR NUD.IST: qualitative data analysis software*. London: Sage.

Scottish Office Department of Health (1998). *Acute Services Review*. Edinburgh: HMSO.

Seidel J, Kelle U (1995). *Computer-aided Data Analysis: theory, methods and practice*. London: Sage.

Sherblom S, Shipps T B, Sherblom J C (1993). Justice, care, and integrated concerns in the ethical decision making of nurses. *Qualitative Health Research*, 3, 4, 442-464.

Shotter J (1984). *Social Accountability and Selfhood*. Oxford: Blackwell.

Silverman D (1993). *Interpreting Qualitative Data: methods for analysing talk, text and interaction*. London: Sage.

Silverman D (2000). *Doing Qualitative Research: a practical handbook*. London: Sage.

Singer P (1979). *Practical Ethics*. Cambridge: University Press.

Smith P A (1988). *Quality of Nursing and the Ward as a Learning Environment for Student Nurses: a multi-method approach*. University of London: Unpublished PhD Thesis.

Smith P A (1992). *The Emotional Labour of Nursing*. London: Macmillan.

Sourial S (1997). An analysis of caring. *Journal of Advanced Nursing*, 26, 1189-1192.

Stein L (1967). The doctor-nurse game. In Dingwall R, McIntosh J (Eds) (1978) *Readings in the Sociology of Nursing*. Edinburgh: Churchill Livingstone.

Stein L, Watts D, Howell T (1990). The doctor-nurse game revisited. *New England Journal of Medicine*, 322, 8, 546-549.

Strauss A L (1987). *Qualitative Analysis for Social Scientists*. Cambridge: Cambridge University Press.

Strauss A L, Corbin J (1990). *Basics of Qualitative Research: grounded theory procedures and techniques*. Newbury Park, California: Sage.

Swanson J M (1986). The formal interview. In Chenitz W C, Swanson J M (Eds) *From Practice to Grounded Theory - qualitative research in nursing.* Menlo Park, California: Addison-Wesley Publishing Co.

Sword W (1999). Accounting for presence of self: reflections on doing qualitative research. *Qualitative Health Research,* 9, 2, 270-278.

Tappan M (1987). *Hermeneutics and Moral Development: a developmental analysis of short-term change in moral functioning during late adolescence.* Harvard University: Unpublished Ed.D. Dissertation.

Tappan M (1989). Stories lived and stories told: the narrative structure of late adolescent moral development. *Human Development,* 32, 300-315.

Thomas C (1993). Deconstructing concepts of care. *Sociology,* 27, 4, 649-669.

Thompson I E, Melia K M, Boyd K M (4th ed) (2000). *Nursing Ethics.* Edinburgh: Churchill Livingstone.

Tronto J (1987). Beyond gender difference to a theory of care. *Signs,* 12, 4, 644-663.

Uden G, Norberg A, Lindseth A, Marhaug V (1992). Ethical reasoning in nurses' and physicians' stories about care episodes. *Journal of Advanced Nursing,* 17, 1028-1034.

Ungerson C (1983). Why do women care? In Finch J, Groves D (Eds) *A Labour of Love: women, work and caring.* London: Routledge and Kegan Paul.

Ungerson C (1987). *Policy is Personal: sex, gender and informal care.* London: Tavistock.

United Kingdom Central Council (1986). *Project 2000: a new preparation for practice.* London: United Kingdom Central Council.

United Kingdom Central Council (1987). *Project 2000: the final proposals.* London: United Kingdom Central Council.

United Kingdom Central Council (1998). *Guidelines for Records and Record Keeping.* London: United Kingdom Central Council.

United Kingdom Central Council (1999). *Fitness for Practice: the UKCC Commission for nursing and midwifery education.* London: United Kingdom Central Council.

Valentine K L (1991). Nurse-patient caring: challenging our conventional wisdom. In Gaut D A, Leininger M M, *Caring: the compassionate healer*, New York: National League for Nursing.

Vitz P C (1990). The use of stories in moral development: new psychological reasons for an old education method. *American Psychologist*, 45, 6, 709-720.

Vogel Smith K (1996). Ethical decision-making by staff nurses. *Nursing Ethics*, 3, 1, 17-25.

von Essen L, Sjoden P -O (1991). Patient and staff perceptions of caring: review and replication. *Journal of Advanced Nursing*, 16, 11, 1363-1374.

von Essen L, Sjoden P-O (1995). Perceived occurrences and importance of caring behaviours among patients and staff in psychiatric, medical and surgical care. *Journal of Advanced Nursing*, 21, 266-276.

Walker K, Avant K (3rd ed) (1995). *Strategies for Theory Construction in Nursing*. Norwalk, NJ: Appleton and Lange.

Watson J (1979). *Nursing: a philosophy and science of caring*. Boston: Little, Brown.

Watson J (1988). *Nursing: human science and human care*. New York: National League for Nursing.

Watson J (1990). Caring knowledge and informed moral passion. *Advances in Nursing Science*, 13, 1, 15-24.

Watson R, Lea A (1997). The caring dimensions inventory [CDI]: content validity, reliability and scaling. *Journal of Advanced Nursing*, 25, 87-94.

Watson R, Deary I J, Lea A (1999a). A longitudinal study into the perceptions of caring and nursing among student nurses. *Journal of Advanced Nursing*, 29, 5, 1228-1237.

Watson R, Deary I J, Lea A (1999b). A longitudinal study into the perceptions of caring among student nurses using multivariate analysis of the Caring Dimensions Inventory. *Journal of Advanced Nursing*, 30, 5, 1080-1089.

Webb C (1992). The use of the first person in academic writing: objectivity, language and gatekeeping. *Journal of Advanced Nursing*, 17, 747-752.

Webb C (1996). Caring, curing, coping: towards an integrated model. *Journal of Advanced Nursing*, 23, 960-968.

Webb C (1999). Analysing qualitative data: computerised and other approaches. *Journal of Advanced Nursing*, 29, 2, 323-330.

Westermark E (1960). *Ethical Relativity.* Patterson, NJ: Littlefield, Adamo (originally published in 1932)

White R W (1981). Humanitarian concern. In Chickering A, *The Modern American College*. San Francisco: Jossey-Bass.

Wilkes L M, Wallis M C (1993). The five C's of caring: the lived experiences of student nurses. *Australian Journal of Advanced Nursing*, 11, 1, 19-25. Cited by

Wilkes L M, Wallis M C (1998). A model of professional nurse caring: nursing students' experience. *Journal of Advanced Nursing*, 27, 582-589.

Wilkes L M, Wallis M C (1998). A model of professional nurse caring: nursing students' experience. *Journal of Advanced Nursing*, 27, 582-589.

Wolf Z R (1986). The caring concept and nurse identified caring behaviours. *Topics of Clinical Nursing*, 8, 2, 84-93.

APPENDIX ONE

The 1992 Diploma of Higher Education in Nursing

The initial 18 months of the Diploma Programme comprised a Common Foundation Studies component, undertaken irrespective of the Branch of nursing practice in which the student intended to specialise (ie Adult, Child, Mental Health, Learning Disability). It was indeed possible for students to refrain from making their final selection of a Branch programme until close to completion of their Foundation Studies, the rationale being that this provided the opportunity for students to undertake practice placements in each Branch of practice prior to finalising their choice.

On commencement of Foundation Studies the students spent two 10 week terms in college, acquiring theoretical knowledge, followed by two 5 week practice placements, in two of the four Branch specialties. They returned for another 10 week term in College and subsequently spent two 5 week placements within the other Branch specialties. The following term comprised theoretical input in college and a 4 week practice placement within a care of the elderly setting. During this initial 18 month period the students completed written assignments, including a study of a patient/client for whom they had provided care during a practice placement, and a timed, invigilated examination.

Within the university setting, students were allocated on commencement of their studies to a specific lecturer, designated as their personal tutor. This person provided academic support for the student during compilation of their early theoretical assignments, recorded their practice placement progress and provided pastoral support if required. The personal tutor also provided referral to other resources if these were deemed to be necessary, such as the student counselling service, or occupational health.

Successful completion of the Foundation Studies' programme entailed completion of theoretical work to the level of a pass grade and satisfactory practice placement assessments. During placement the students were allocated to a registered nurse who acted as their 'mentor'[1] and who had primary responsibility for the student's

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[1] The term agreed upon by the educational institution and service providers.

assessment. The students' assessment booklets comprised learning outcomes[2], attainment of each being verified by the mentor, or another registered nurse. The mentor was responsible for the day to day supervision of the student and, in conjunction with other qualified staff, negotiated the student's hours of work (totalling thirty hours per week, over a five day period) and learning experiences. The mentorship system worked well in some areas and less so in others. In some instances, the student's opportunity to work alongside their mentor was limited, due to the latter being absent as a result of night duty allocation, holiday, illness, or due to having insufficient time to mentor the student. In instances in which there was conflict between the mentor's diverse clinical responsibilities, student teaching and supervision was frequently the casualty.

During all placements within the Foundation Studies' programme, the students were supernumerary, ie although they participated in care delivery, this was (supposedly) carried out under the supervision of registered nurses and students were not formally regarded as an integral part of the workforce. The United Kingdom Central Council's (UKCC)[3] (1986, 1987) *Project 2000* proposals stipulated that nursing students' educational preparation for practice be removed from service jurisdiction, although during some of the later Branch programme placements students undertook rostered service, which entailed being counted as integral to the staffing levels within the placement. It should be said that the students' supernumerary status was not always honoured in practice, some placement staff and managers using students as an integral part of their workforce.

Following successful progression from Foundation Studies to the Branch-specific programme, students undertook a further 18 months of study within academic and practice placement settings, all of which focused upon the student's selected Branch of nursing.

Mentor preparation comprised attendance at study days, and a period of guided study, organised by the College of Health Studies.
[2]These related to psychomotor and psychosocial skills and to organisational competence.
[3]The United Kingdom Central Council is the statutory body responsible, in conjunction with the National Board for Nursing, Midwifery and Health Visiting for Scotland (NBS), for the preparation for practice of nursing students (and the ongoing fitness to practice of registered nurses, midwives and health visitors).

The curriculum throughout the three year programme was structured around the following seven themes: nursing; social and behavioural science; life science; health; organisation, structure and process; communication; professional, ethical and moral. Although these were taught as separate entities, efforts were made to explicate the inter-relationship between the themes in the overall provision of health care and to emphasise the relationship between theory and practice.

The impact of organisational structures

The provision of a national health service within the UK entailed the formation and subsequent maintenance of a monolithic organisation, in order to meet the needs of a population in excess of fifty million. The principles upon which it was founded in 1948 were that access to health care should be available 'from the cradle to the grave', should be determined by an individual's need and should be free of charge at the point of delivery. Whilst the ideology which drove the inception of the NHS created an organisational framework, the aim of which was facilitation of health care delivery, the reality of the complex structures required to deliver health services to individuals with diverse health care needs has sometimes inhibited, rather than facilitated, achievement of this aim. The individuals who work, and/or receive care, within the system have to contend with, and negotiate, the organisational structures in order to achieve their own aims. Similarly, the structures which provided the educational preparation for practice of members of the care team have ostensibly facilitated, but at times inhibited, achievement of their purported aims. Perennial tensions have existed between the demands exerted by health service provision and the educational needs of nursing students. Students, prior to implementation of the Diploma of Higher Education in Nursing ('*Project 2000*') programmes, undertook periods of theoretical input within colleges or schools of nursing, followed by periods of clinical practice, during which time they were regarded as integral, and vital, to the workforce. They received a salary during their programme, paid by the service providers.[4]

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[4]The comments made here refer to students of nursing, whose preparation for practice was previously undertaken in schools or colleges of nursing (and which subsequently amalgamated with higher education in the 'new' university sector). They do not refer to those undertaking degree programmes of preparation for

It was the perceived inadequacy of this system, and the manner in which it prioritised the needs of service provision at the expense of the students' educational needs, that led to the transfer of nurse education to the higher education sector and accorded students supernumerary status for the majority of their practice placement allocations. This entailed, however, that students, instead of operating within one organisational framework, were now required to negotiate two. They had to contend, not only with the ethos and demands exerted by their educational programme within a university, but also with the ethos and demands of health care settings. Although it may be argued that the philosophy within the previously existing colleges and schools of nursing was in some respects at variance from that of the service providers, it was at least the case that both had the same paymaster and overall agenda. Whilst this constituted part of the problem that led to the necessity for a formal distance between education and service, the separation of the two has arguably removed the latter to a greater distance from the front-line of care delivery. Lecturers have clinical links, but the extent to, and manner in, which these are maintained is widely variable. This is not necessarily resultant from any individual's predilection for, or aversion to, maintenance of clinical contact, but is quite frequently imposed by the organisational constraints under which lecturers now operate. The universities with which they amalgamated have the expectation that lecturers will not only teach and retain clinical credibility, but actively participate in potentially income-generating research activity. Thus, the tensions which preceded implementation of the *Project 2000* proposals were in some ways alleviated, but in others compounded, by the clear differentiation between education and service, lecturers becoming even more vulnerable than previously to the charge of working within an 'ivory tower', removed from the realities of nursing practice. The existence of these tensions invariably impacts upon the student experience, both within the organisational framework of the university and that of the health service.

The students in my study did not commence their programme until 1995, by which time some of the initial problems encountered by students undertaking the 1992 programme had been alleviated, if not in every instance overcome. Anecdotally, following implementation of the 1992 programme, students undertaking practice

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practice in the old-established universities.

placements encountered attitudes ranging from enthusiasm for, non-comprehension of, or hostility to, the new preparation for practice. Some registered nurses, whose qualification from earlier programmes had been a certificate, and who were under pressure from management to continue their education (on a part-time, frequently unsupported basis) to diploma or degree level, demonstrated some resentment of the fact that students undertaking the 1992 programme would, upon its successful completion, emerge with a diploma, from which a 'top-up' to degree level required attainment of only 120 additional CAT [5] points.

The 1992 Programme students' supernumerary status attracted some adverse reaction and the perception of many students was that they were not regarded as part of the care team but, rather, as unwanted visitors, the purpose of whose allocation was unclear to many permanent staff. Whilst some students undoubtedly had positive experiences, others were asked to implement care activities for which they had received no prior preparation for practice, whilst others were relegated to a purely observational role or, in some instances, were directed to sit in a side room and read the patients' casenotes, or a textbook. (Whilst the focus within this thesis is upon students' perceptions, it should also be aknowledged that anecdotal evidence from qualified staff in placement areas in relation to the 1992 students' abilities and behaviours indicated that the latter may, in some instances, have contributed to the problems that they experienced.)

As stated earlier, the students within my study commenced their programme in 1995, by which time many of these earlier problems had diminished in significance, although the students' accounts indicated the existence, in some instances, of problems predicated upon their status as 'new' programme students.

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[5]Credit Accumulation Transfer (SCOTCAT in Scotland). These are numerical points, awarded by individual educational institutions as a form of credit rating, but considered to be standardised and therefore transferable. They are awarded at levels one, two or three, dependent upon the expected standard of achievement. They may be accumulated towards award of certificate, diploma, or degree. Student nurses who successfully complete the diploma in higher education (nursing) are awarded 240 points; 360 are required for award of a degree. Registered nurses who undertook a nurse preparation programme in Scotland from 1982 onwards are eligible for a CAT award of 90 points. Registered nurses whose preparation for practice pre-dated 1982 are not accorded CAT recognition.

APPENDIX TWO

Interview Schedule

Date of Meeting	**Stage within 3 year programme**
August-September 1996	Term 4: subsequent to practice placements 1 & 2 (Paediatric and Mental Health)
January-February 1997	Term 6: subsequent to practice placements 3 & 4 (Adult and Learning Disability + for some students, Care of the Elderly)
October-November 1997	Term 9: subsequent to first practice placements within Branch-specific programme
August 1998	Term 12: subsequent to final practice placement