

**PICTURES IN THEIR MINDS:
AN ANALYSIS OF
STUDENT NURSES' IMAGES OF NURSING**

Alice M Kiger

**PhD
University of Edinburgh
1992**



I declare that this thesis was composed by me and that the work is entirely my own. No part of it has been submitted for any other degree or professional qualification.

ACKNOWLEDGEMENTS

I would like to acknowledge the efforts of those individuals who helped me through the process of planning, carrying out, and writing up the research study that is reported in the pages of this volume.

Firstly, I thank my supervisors at Edinburgh University: Dr Kath Melia for her wise and understanding guidance throughout the research study and the writing of the thesis; and Professor Penny Prophit for her helpful suggestions and inspiration at critical junctures.

I am grateful to my colleagues in the Education Department at the University of Aberdeen for their tolerant cooperation and encouragement during the past four years, and their empathy with my plight as a part-time PhD student.

My thanks also go to Sandra Inglis for her support during my early days as a post-graduate research student, while I was a nurse teacher at Foresterhill College.

I thank the staff of “Scotsburgh College” and its associated clinical areas, for their cooperation in facilitating the conduct of the data collection. Most especially, I thank those students of “Scotsburgh College”, from “Angela” to “Zena”, who so willingly shared with me their images of nursing, and much more besides.

Finally, I offer my very personal thanks to Tony Wilson for hours and hours of patient listening, discussing and proofreading, and for giving me strength.

ABSTRACT

This study explored student nurses' images of nursing from their point of entry to training through their early experiences of clinical nursing. The research approach was based on Glaser and Strauss's principles for the generation of grounded theory, and the techniques of comparative analysis and theoretical sampling were employed.

Student nurses from three intake groups at a single Scottish nursing college provided the population from which subjects were chosen. Following a short exploratory questionnaire administered to each student cohort, the primary means of data collection was through informal in-depth interviews, and twenty-four students were selected for this purpose. Among the twenty-four, all four branches of nurse training were represented (general nursing, mental handicap nursing, mental nursing, and sick children's nursing). Ages of interviewees ranged from seventeen to thirty-six years, and three of the students were male. Three rounds of individual interviews were conducted, the first being undertaken prior to the students' clinical experience, the second during their second clinical placements, and the third during their fourth or fifth clinical placements.

Analysis of the first interviews revealed five major themes in the students' initial images of nursing: "pictures of nursing", "the good nurse", "what nursing entails", "occupational labels for nursing" and "being a student – becoming a nurse". These themes were pursued in the later interviews and the characteristics of the students' experience-mediated images were identified. In addition, the processes through which students' images developed were analysed. These included the process of affirmation, when initial images were congruent with experience, and processes of accommodation and non-accommodation to disparity when image and experience lacked congruence. Associated processes which either facilitated or inhibited perceived affirmation or accommodation of the image included identification, disillusionment, and extenuation.

A number of findings were highlighted. The picture of adult general nursing as typical or real nursing was evident in initial interviews, and this persisted in later interviews as well. This was true even for students who were undertaking training in one of the three other fields of nursing. "Working with people" and "helping" appeared consistently in the students' images as central characteristics of nursing. Notions of "the good and the bad" of nursing were found to underlie many features of the image. The paradoxical nature of "involvement" within the image was particularly noticeable. The presence of staff (good and bad) was prominent in students' images as being instrumental in determining the quality of their experience and the development of their images. There was clear evidence of the importance of support to enable students to adapt to disparities between their images and perceived reality. The concepts of commitment and belonging were integral to students' images of nursing and made it more than just a job. In this, it was seen to have features in common with other health care fields, but also particularly with police work.

CONTENTS

	<i>Page</i>
Declaration	i
Acknowledgements	ii
Abstract	iii
Contents	iv
List of Figures	viii

Introduction	1
-------------------------------	----------

PART 1: BACKGROUND

Chapter 1: IMAGES AND IMAGERY	5
Nature, Origin and Types of Images	5
Eliciting Data on Images	15
Chapter 2: SOURCES OF OCCUPATIONAL IMAGE	19
Lay Literature for Young People 1: Children	19
Lay Literature for Young People 2: Teenagers	20
Careers Material	20
Fiction	23
Professional Recruiting Literature	25
Television Documentaries	27
Television Fiction	28
Comment on Image Sources	29

PART 2: METHOD AND DESIGN

Chapter 3: METHODOLOGICAL ISSUES	31
“Generation of Grounded Theory” as a Research Approach	31
The Relevance of Grounded Theory to	
Research in Nursing and Nursing Education	34
Comparative Analysis and Theoretical Sampling	35
The Type of Theory Generated	43
The Use of Interviewing in Qualitative Research	47

Chapter 4: STUDY DESIGN AND DATA ANALYSIS	51
The Interviewees	51
The Data Collection	55
Administration of Questionnaires	55
Conduct of Interviews	56
A Comment on the Researcher's Role	62
Ethical Issues	64
Issues of Reliability and Validity	64
Approach to Analysis of Interview Data	68
Discovering Theory Through Comparative Analysis	68
Properties and Dimensions	72
Developing Relationships	73
Selecting the Core Category	74
Note on Presentation of Data	75
The Order of Presentation	75
Quotation	75
Changes, Omissions and Nonverbal Elements	77

PART 3: THE IMAGES

Chapter 5: BEGINNERS' IMAGES	80
PICTURES OF NURSING	80
Typical Picture	81
Entry Pictures and Revised Pictures	83
Specialist Pictures	87
Picture of a Nurse	90
THE GOOD NURSE	95
Cheerfulness	96
Understanding and Communication	97
Involvement, Feelings and Selflessness	98
Dedication	102
Loyalty and Dependability	103
Person and Personality	104
STUDENTS' IMAGES OF WHAT NURSING ENTAILS	106
The Nature of the Work	106
Satisfactions and Rewards: "The Good"	109
Seeing Improvement	110
Making Things Better	111
Personal Satisfaction	112
Getting Thanks	112
Meeting People	113
Difficulties and Unpleasantness: "The Bad"	114
Death, Suffering and Giving Bad News	114
Other Dreads	116
Difficult People	117
Organization-Related Features	118
Getting Involved	119

OCCUPATIONAL LABELS FOR NURSING	122
“Not Just a Job”	122
Profession	127
Career	128
Vocation/Calling	131
BEING A STUDENT – BECOMING A NURSE	132
Sources of Image	133
Contact with Nurses	133
The Media	138
Careers Material	144
Unknown	146
Choosing a Career	146
Feelings about Doing Nursing	153
Becoming a Nurse	159
Summary of Beginners’ Images	163
Chapter 6: IMAGES FROM THE INSIDE	167
PICTURES OF NURSING	168
THE GOOD NURSE: STAFF, GOOD AND BAD	171
STUDENTS’ IMAGES OF WHAT NURSING ENTAILS	177
The Nature of the Work	178
The Good and the Bad	180
Getting Involved	188
Dealing with Death	193
OCCUPATIONAL LABELS FOR NURSING	200
BEING A STUDENT – BECOMING A NURSE	202
Choosing a Career: Police Work	203
Being a Student 1: Living with the Requirements	205
Being a Student 2: Settling In	214
Being a Student 3: Stress and Support	217
Becoming a Nurse	220
Summary of Inside Images	223
Chapter 7: SHIFTING IMAGES	228
Overview of the Processes	228
PERCEIVED AGREEMENT BETWEEN IMAGE AND REALITY: AFFIRMATION	230
PERCEIVED DISPARITY BETWEEN IMAGE AND REALITY	232
Processes of Accommodation	232
Modification	232
Transformation	239

Processes of Non-Accommodation	240
Rejection	240
Persistence	245
RELATED PROCESSES	247
Identification	247
Disillusionment	249
Extenuation	251
 Comment on the Processes	 252
 Chapter 8: CONCLUDING DISCUSSION	 254
A Note on Limitations	254
Discussion	255
 Appendices	
Appendix 1: Questionnaire Part 1	267
Appendix 2: Questionnaire Part 2	269
Appendix 3: Publication	271
 References	 281

LIST OF FIGURES

	<i>Page</i>
Figure 1.1: Richardson's types of images	6
Figure 1.2: Pictoriality/descriptiveness of images	13
Figure 3.1: Comparison of theoretical sampling and statistical sampling approaches	39
Figure 3.2: Steps in Glaser and Strauss's strategy for generating grounded theory, as outlined by three grounded theorists	42
Figure 4.1: Numbers of student subjects	54
Figure 4.2: Plan of first stage of training	57
Figure 4.3: Sequence of entry groups (first year of data collection)	58
Figure 4.4: Sequence of entry groups (second year of data collection)	58
Figure 4.5: Dimensions of "staff"	72
Figure 5.1: Entry image categories and their properties	164
Figure 6.1: Inside image categories and their properties	224
Figure 7.1: The processes of image development	229

INTRODUCTION

"Nursing has always had a problem with its image."
(Gaze 1991)

The occupational image of nursing has received considerable attention in the nursing press over recent years. Members of the profession are concerned about what they perceive as inaccurate or outdated portrayals, particularly in the media. There are many reasons for this concern, one being the influence of the public image on candidates (or potential candidates) for nurse training. Snow-Antle, for example, has referred to the dangers of erroneous public stereotypes which, she says

distort the public's concept of nursing, affect the quality and number of people entering the profession, affect the decisions of policy-makers on allocation of resources for the profession, and deprive consumers of knowledge of the vital services nurses provide. (1984:54)

Major elements that professionals bemoan in nursing's image include the well-known trio of "angels, sex symbols and dragons" (Hunt 1984:54). A further and arguably more important element is referred to by Gaze (1991:17) when she cites the case of an undergraduate student nurse who "feels intellectually inferior to medical students." The implication, she says, is that "if you are clever you become a medical student and if you are not, you become a nurse." A corollary to this has been described by Salvage:

We may see ourselves as skilled practitioners, but the public still clings to its old image of the nurse as the doctor's handmaiden.

She goes on to indicate the implications of these image problems for recruitment:

A negative public image, which emphasises supposedly instinctive 'feminine' attributes and excludes the fact that good nurses are intelligent and well-educated as well as compassionate, has bad effects on recruitment. Well qualified women and men seeking a career which is stimulating and intellectually demanding are hardly likely to choose nursing if the images they see are 'dumb blondes' and 'flint-hearted matrons'. (1983:181)

The nursing profession has attempted to project a "better" image via recruitment campaigns. An example can be found in a current two-page advertisement running in popular magazines. A photograph occupying three-quarters of the advertisement depicts a young man crouching under a small table, holding his hands to his head and looking distraught. The heading is: "All day long he heard strange voices. So why did he listen to mine?" The brief story of Mark is offered, indicating that he was suffering from auditory hallucinations and was admitted to a mental hospital. There,

during six weeks of treatment, a Registered Mental Nurse played a major role in his recovery. The desired nursing image is apparent:

From Mark's story you may have gathered that being an RMN takes a great deal of patience, resilience and sensitivity. It also takes three years of intensive training. But think what you get out of it. The satisfaction of knowing that you've helped a sick person get well.

(*Radio Times*, 9-15 November 1991:58-59)

It could be argued that this advertisement does not adequately imply that nursing is *intellectually* demanding. It might also be contended that whereas such an advertisement might go some way towards ameliorating the traditional negative stereotypes, it may introduce other problems. It contains strong implications of independence of nursing action; practising nurses may not agree that such a degree of independence actually exists in their working context. It refers to the "sick person get(ing) well"; the Mark of the advertisement is apparently schizophrenic, and is highly unlikely to have got well through a six-week course of treatment. Such features may elicit unreasonable expectations in candidates if they are not matched by the experience that will be encountered in nursing.

These aspects of the image to which the public is exposed suggest a number of questions relevant to entrants to nursing. What potential sources of image actually influence candidates for nursing? In what way are they influenced? What are the short-term and long-term implications of a disparity between an outdated or inaccurate image and "real" present-day nursing?

Melia, in her study of nurses' occupational socialization, has suggested that the potential for creating disparities extends beyond the influences that shape candidates' images prior to their entry to training. Once students join the institutional context, they are presented with a professional image to which they are expected to subscribe.

One of the abiding problems of occupational socialization has to do with the differences between the idealized version of work as it is presented to new recruits and the work as it is practised daily by members of the occupation. (Melia 1987:1)

This implies another question, the answers to which must necessarily become entangled with the answers to the questions posed above: What are the implications of a disparity between a professionally idealized image and a less ideal reality?

The research study reported in this thesis addressed such questions in an exploration of student nurses' images of nursing. It sought to identify features of the images with which students entered training and to investigate the development of their images as they were exposed to the culture of their training institution and as they

participated in nursing first-hand. Underlying the investigation was an attempt to discover the significance of disparities for the development of students' images.

To explore this topic, it was necessary to seek an understanding from the students' own perspective. Thus the study was phenomenological in nature and utilized a qualitative research approach. The approach selected was based on the principles identified by Glaser and Strauss (1967) for the generation of "grounded theory". Data were collected through interviews with student nurses at three points in their training, once before they were allocated for clinical experience, once during their second clinical allocation, and once during their fourth or fifth clinical allocation.

Initially the aims of the study were twofold:

- to identify characteristics of the nursing images with which students embarked upon their nursing education experience; and
- to discover what became of those images once the students encountered the "real world" of nursing.

As the study progressed and theory emerged during the later stages of data collection, an additional aim was identified:

- to discover the processes through which students' images developed from their initial form into their experience-mediated form.

The conceptual context of the study is established in Part 1 of the thesis. This comprises a consideration of imagery and image development (Chapter 1) and a discussion of literary and television influences to which candidates may be exposed and which may help shape their images of nursing (Chapter 2). Literature and research specifically related to the substantive area of study are not considered at this point, but are discussed as they become relevant to the discussion in Part 3.

In Part 2, issues related to research method are explored (Chapter 3) and the design of the study is described and explained (Chapter 4).

Part 3 contains a discussion of the results, with supporting evidence from the data, addressing first the themes that arose from the initial round of interviews (Chapter 5) and then those from the second and third rounds of interviews (Chapter 6). There follows a consideration of the processes that were involved as the students' images developed over time (Chapter 7). A concluding discussion (Chapter 8) is then offered.

PART 1

BACKGROUND

Chapter 1

IMAGES AND IMAGERY

The purpose of this chapter is to establish a conceptual frame of reference for the study in relation to the central element of its focus, that is, the “image of nursing” as it was represented by student nurses. The sense in which the term “image” is used in the study and how it relates to the data are clarified. Elements of the analysis of data which are reported in later chapters are pre-empted to demonstrate the relevance of the material discussed.

The analysis which follows centres on those elements in image and imagery literature that are relevant to the present purpose, the material being drawn primarily from psychology. It first considers what images are, and then discusses how data on images can be elicited for research purposes.

Nature, Origin and Types of Images

Every man walks around in the world enveloped in a carapace of his own images. Their presence enables him to structure and to organize the multiplicity of the objects and the stimuli which throng upon him; but their presence also distorts, so no one ever perceives exactly what there is in this world or all there is in this world. Yet, man lives in his carapace as naïvely, innocently, and unwittingly as does the fish in his water, the bird in the air, or the baby in the womb. (Gordon 1972:63)

Images, by this description, inevitably play a significant role in a person’s view of the world, and therefore in influencing the person’s approach to interacting with that world. It is upon this sort of premise that the belief in the value of the present study was based. A student nurse entering training must have a mental image of nursing, whether she is aware of it or not, and it seems reasonable to assume that the nature of that image may influence both how the student perceives and interacts with the “world of nursing”, and how that “world” affects her.

What then are these ubiquitous images that envelope us in our world, and that help (or hinder) us in structuring and organizing “the multiplicity of the objects and the stimuli which throng upon (us)”? Horowitz (1972:282) has said that an image is “a representation of information that has a sensory quality when that representation is consciously experienced.” The sensory quality can be in any sensory mode, although visual images are the most commonly discussed. Gordon (1972:63) specifies further that an image is a representation which occurs “in the absence of an actual external stimulus which could have caused such perception”. Gordon does not mean that the

image bears no relation to an external stimulus, which may have been present in the past, only that the stimulus is not present at the time the representation is experienced.

Morris and Hampson (1983:4) offer a clarification of this point:

Imagery can (...) be considered a phenomenon which stands at the intersection of memory and perception, where it can be used to aid conscious thinking and problem solving. As a perceptual phenomenon imagery owes its content and possibly also its structure to information originally derived through the senses. This implies no more than that we can have images of particular objects or events, and that at least some of the information underpinning our images of those events must, at some time, have been gained through perception.

The information, Morris and Hampson say, must have been stored before it can be represented in imagery; “imagery thus has memorial properties.”

Imagery is often divided into four classes: after-imagery, eidetic imagery, memory imagery, and imagination imagery. Richardson (1969:128) does not see the four types as discrete classes, but suggests that they can be seen as being on a continuum. A diagram can be constructed from his description as follows:

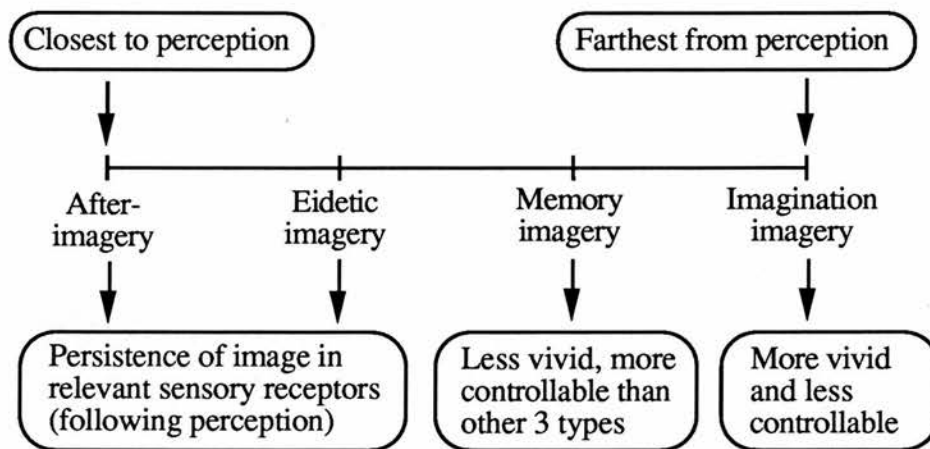


Figure 1.1

Since after-imagery and eidetic imagery both relate to the persistence of the effects of a visual event in the relatively immediate aftermath of the experience of the stimulus, they are not of direct concern in the present study and are not considered in any detail here.¹ Both memory imagery and imagination imagery are relevant and are therefore discussed further.

¹ Discussion of after-imagery can be found in Paivio (1971:99ff), Neisser (1976:31-32), Kosslyn (1983:80-81), and Morris and Hampson (1983:74-76). Eidetic imagery is discussed in Paivio (1971:481-82), Neisser (1976:150), and Morris and Hampson (1983: 85-89).

Richardson (1969:43) identifies memory imagery as “the common and relatively familiar imagery of everyday life.” He says that it may accompany “the recall of events from the past, the ongoing thought processes of the present, or the anticipatory actions and events of the future.” It is typically “like a hazy etching, often incomplete and usually unstable, of brief duration and indefinitely localized.” These characteristics seem to apply to the student nurses’ accounts of their images of nursing. That is, they were often hazy pictures, tied up with past experiences but not usually specific recollections of scenes or events (though specific recollections did sometimes come into the conversation), and they were intertwined with the students’ activities of the present and immediate future, especially in the first round interviews.

Imagination imagery has been contrasted with memory imagery in seminal work by Perky (1910:436), who identified

on the one hand, images of recognized and particular things, figuring in a particular spatial context, on a particular occasion, and with definite personal reference; (...and) on the other hand, images with no determination of context, occasion, or personal reference,—images of things recognized, to be sure, but not recognized as this or that particular and individual object. The former were evidently ‘images of memory’; the latter, both by positive and negative character, were ‘images of imagination’. In other words, we have (...) a rough and ready criterion of the two types of image: memory being distinguished by particularity and personal reference, and imagination contrasting with it by lack of particularity (in the sense of a particular sample, placed and dated) and absence of personal reference. ...

Again with imagination imagery, there seem to be strands of similarity with students’ descriptions of their images of nursing. Some students described a nurse or a nursing scene in a mental picture, and found their picture to be contrary to their memory representations. In some cases, there were vivid elements contained in these (apparently) imagination images, such as the big fat smiling nurse with rosy cheeks described by one student. With regard to the low controllability of imagination imagery illustrated in the earlier diagram, it may be that what was attempted in this study was to encourage the students to grab such elusive images and bring them into consciousness for inspection. This might be similar to asking someone immediately upon waking up to think about what they were just dreaming of. In both cases, there is no assurance that there is anything there to find, but the hope is that there will be. The potential dangers of this are discussed in the next section, in relation to the usefulness of introspection as a source of data.

Morris and Hampson’s discussion of memory image and imagination image reinforces and slightly expands the explanations already given. They describe memory image, which is probably the most common type, as the “imagery of some past

experience which is aroused from memory” (1983:65), and which is recognized as internal. It may occur spontaneously or may be intentionally called up. Imagination imagery they describe as “images which, while incorporating elements of past experiences, are themselves newly composed and do not represent a memory of some specific past event” (1983:66). These, too, are internal, and may occur voluntarily or without conscious effort.

Like Richardson, Morris and Hampson suggest a continuum, though only in relation to memory and imagination imagery:

... while logically distinct, memory and imagination images may represent ends of a continuum rather than distinct types. All memory images will probably represent a reconstruction rather than an accurate reproduction of the visual scene, and imagination images must draw on memory information. (1983:67)

Horowitz suggests a complex system of categorization. She categorizes images according to (1) vividness, (2) context, (3) interaction with perception, and (4) content. Within these areas, different types of images are discussed, from hallucinations to after-images. Of concern to this study, “thought images” are described within the first category (1978:10-11). It is said that their “vividness may range from relatively weak to very clear,” and that thought images are intrapsychic, that is, they are localized internally. They seem like memory or imagination. Thus it would seem that Horowitz’s thought images perhaps include Richardson’s memory images and imagination images. The content of images, Horowitz says (1978:10), ranges “from fantasy to visualizations of logical problems in geometry.”

Within the categories of “context” and “interaction with perception”, Horowitz does not discuss any types of images that appear to relate to the images described in this research. She does not mention thought image in these two categories, which seems odd, since it would seem that thought images would have contextual and perceptual features.

Both memory image and imaginary image are discussed within Horowitz’s “content” category. These are described in terms similar to Richardson’s and Morris and Hampson’s. Memory image is “a reconstruction of a past perception.” In contrast, “imaginary image (...) contains contents that have never been perceived within that particular organization. The component parts (...) are derived from images of past perceptions and recombined to form new concepts and fantasies” (1978:24-25).

Horowitz’s categories are awkward, in that the sub-categories within them seem to be handled inconsistently from one category to another. The system does, however, provide further basis for considering that the imagery explored in the present study is

most closely related to memory and/or imagination images, possibly within the overall umbrella of thought images.

Holt emphasizes that an image is not simply a replica of the outer world — it is neither simple nor a mere replica.

... perception is a highly selective process (...) in the coming about of the visual image there must be a preliminary stage in which the nascent perceptual presentation is matched with stored memory presentations, which must be scanned until the correct match is found. (1972:10)

Implicit in this is the inextricable relationship between perception and image, but that relationship is not one of exact equivalence.

... all images are the end product of a process of construction, and (...) the usual dichotomy of percept vs. mental image should be replaced by a continuum on which these opposed notions are ideal cases rarely if ever attained in reality. (1972:11)

Morris and Hampson describe this relationship by saying that imagery is “a phenomenon which stands at the intersection of memory and perception.” They emphasize the role of the memory as the store of information from which an image is constructed. Information originally derived through the senses contributes to the content and perhaps the structure of imagery, which means that perception of past events must constitute at least some of the information that underpins a person’s images (1983:4).

Neisser has also employed the notion of intersection, and considers the interaction between memory and imagery, and the relationship between imaging and perceiving.

If memory and perception are the two key branches of cognitive psychology, the study of imagery stands precisely at their intersection. Our images must be based on what we remember, and in another sense what we remember is often based on images; nevertheless imaging is somehow like perceiving so that we speak of “seeing with the mind’s eye.” (1972:233)

Horowitz further probes these relationships and alludes to the individual’s lack of awareness of the processes and motives involved. She also adds the dimension of emotions to the process of image formation and experience.

... image-formation processes have a transactional relationship with emotions. The immediate emotional state influences image formation, is reflected in image forms and contents (directly or indirectly), and is influenced by the image experience. (1972:293)

This has implications for the data in the present study, as it is reasonable to assume that there may have been an emotional dimension to the interviewees’ mental processing of information about nursing. It is possible that the relationship between the images they

possessed and the memorial elements that went into their formation were influenced by their emotional orientation to the concept of nursing (and vice versa).

Attitudes towards the meaning and implication of information influences [*sic*] the sampling and processing of that information (...) Image contents, and the processes of image formation, are influenced by affective states and the imagery experiences in turn influence affective states. Emotions act as motives for the image formation. Emotions are expressed in the imagery experience. And images evoke emotional responses.
(Horowitz 1972:295)

This does not necessarily cast doubt on the validity of the students' images as images, it simply indicates possibilities about how those images came to be formed and how they may operate on experience.

Horowitz goes on to discuss the processing of an image, which she identifies as being sequential. The steps involve the interpretation of meaning by association with other images in whatever sensory modes they exist, and with verbal meanings. As they go through their developmental stages, images are checked, rechecked, and revised. Then, "once information has been coded at the symbolic level of representation, another sequential step is possible — appraisal of the implications of the information" (1972: 303). The coded information is stored in the memory according to various relevant associational categories. During this process, many changes are possible.

During the process of comparing the new information with preexisting expectancies and schemata there would be change in both the information and the preexisting expectancies and schemata. Hence the result might be a revision of the person's world model, his body image, his expectation of future events, or his current action plans ...
(Horowitz 1972:303)

One curious element in Horowitz's discussion is the allusion to the completion of image formation. She states that image encodings remain in holding operations until completed, then are cleared. They are difficult to complete, she says, under internally or externally imposed stress conditions, and encodings may stay at various sequential levels of processing until completion. This seems to beg the question of when image formation is complete, and how one recognizes that it is. In fact, to suggest that it *can be* complete seems contradictory to the idea of revision of the image resulting from comparison of incoming information with preexisting expectancies and schemata, since information will continue to come in.

The notion of the role of stress is relevant to the present study, particularly to the data from second and third round interviews. Horowitz (1972:304) indicates that stress-related information is "of great subjective importance," and at the same time "difficult to process." It can activate ideational or emotional conflicts, leading to the

inhibition of processing. It was clear in many of the students' later interviews that their experience of nursing so far had entailed a number of stresses, and that these were indeed of great subjective importance to them. In some cases, after experiencing unanticipated stress, they seemed to have lost or discarded elements of their initial images altogether. In other cases, they retained them despite the contradictory information coming in from their experiences. One way of accomplishing this was by maintaining the belief that they had not yet encountered the aspect of nursing that should be expected to fit with their image. In other words, the process of image formation was affected by the fact that they were rejecting incoming information that did not fit, seeing it as being irrelevant to their preexisting expectancies and schemata.

Morris and Hampson offer further discussion about theories of imagery, and what images actually are.

One possibility is that images are like internal pictures or snapshots of things in the world. (...) Another possibility is that imagery is much more abstract than this, more like a description of something than a photograph of it. A yet more radical alternative is that images as such do not exist, but only the processes of imagining. The latter view leads to the conclusion that imagery is a type of mental role-playing or pretending to see, hear or whatever. (1983:119)

Morris and Hampson call these three possibilities "picture theories", "description theories", and "role playing theories", respectively. All three have apparent relationships to the reported images of the student nurses in this study, particularly in their accounts of their "pictures of nursing" and "pictures of a nurse." Some students offered accounts of scenes that were like snapshots or slides, and with encouragement were able to inspect the pictures for further detail. Sometimes this involved an operation that was like zooming in or out with a camera. For example, when asked to describe her image of nursing, a student who offered a ward scene might zoom in on a particular aspect of the scene. On the other hand, a student whose initial response described a nurse at a patient's bedside might zoom out and give an account of the surrounding scene.

Other times students offered word descriptions or explanations that did not seem to be painting a specific picture, but describing something more abstract. There did not seem to be a defined line dividing the pictures from the descriptions, but rather an emphasis on one or the other, or a difference in the degree to which the students' accounts produced a mental image in the listener's mind as opposed to a verbal description that was understandable to the listener in a cognitive sense.

Mental role playing was also evident in some of the students' accounts of their images. In fact, it was often difficult to elicit image pictures or descriptions without the students' placing themselves in the pictures they were describing. It is hard to see how

role playing theories could adequately account for the nature of imagery without having one or both of the other two theories at its base. That is, are not images needed as the props for imagining? One's mental role-playing, it would seem, has to take place in some type of context.

Morris and Hampson (1983:129) differentiate between picture and description theories, indicating that "pictures stand in place of, or re-present things, descriptions on the other hand, tell us what the things are and how they are related."

Picture theories have been discussed in detail in the works of Paivio (e.g. 1969, 1970), Shepard (e.g. 1975; with Podgorny 1979) and Kosslyn (e.g. 1975). Kosslyn offers a particularly interesting explanation by using the metaphor of computer graphics on a cathode ray tube.

The psychological analogue to the cathode ray tube does not display pictures as such, but rather supports internal representations similar to those that arise when pictures are perceived. (...) Like the image displayed on the screen, some type of processor, a "mind's eye" rather than a real eye, is presumed to analyze material arrayed in mental images. (...) Once an image is constructed, it then may be classified according to various conceptual categories. (...) the "mind's eye" can be considered as a set of processes that search for patterns (...) and relationships between patterns in this display. (...) The present claim is that the same procedures may be appropriately applied to classify both internal representations arising during perception which are experienced as a visual percept, and internal representations experienced as a visual mental image. (1975:342-3)

Inevitably, picture theories concentrate on only one sensory mode, namely the visual. The implication seems to be that images in other modes must only be able to fit into descriptive theories, rather than potentially being integrated with the picture.

Description theories have been discussed at length in the work of Pylyshyn. He disputes the "pictorial representation" notion in favour of a representation that is "conceptual and propositional". He suggests that these representations would be "more accurately referred to as symbolic descriptions than as images in the usual sense" (Pylyshyn 1973:1).

Perhaps these two models need not be treated as opposing, though these psychologists appear to treat them as such. It seems reasonable to consider that images may have a bit of both, and it does not seem necessary to view either model as precluding the existence or operation of the other. In many of the accounts of images in the present study, both models seem to be present side-by-side. A composite model could be constructed which placed the dimensions of pictoriality and descriptiveness on perpendicular axes. An image could then be plotted according to the number of pictorial or descriptive elements it contained:

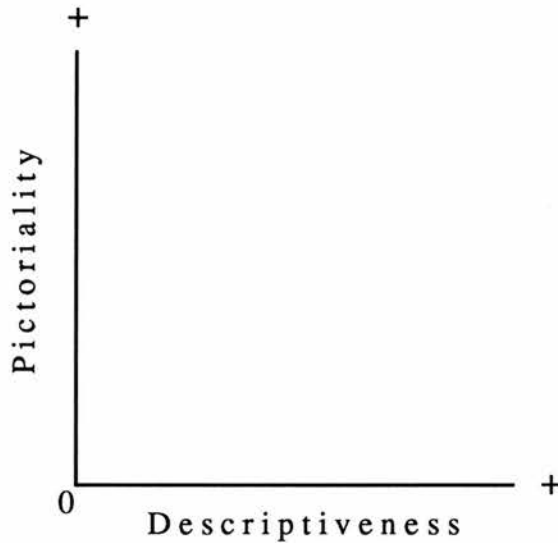


Figure 1.2

In relation to the role playing theories, Morris and Hampson (1983:133) cite the work of Neisser, offering an interesting explanation for how information is processed. Data are received by the organism from information sources in the world. If the organism is in a state of anticipation of readiness, the data are taken into its schemata, and thus knowledge is acquired, and the schemata can then act as plans. Imagery occurs when schemata are in their anticipatory mode and act as if there were information input when there is not. Neisser himself states that

Images are not reproductions or copies of earlier percepts, because perceiving is not a matter of having percepts in the first place. Images are not pictures in the head, but plans for obtaining information from potential environments. (Neisser 1976:131)

Neisser's explanation, however, also seems to allow for elements of the pictorial and descriptive models.

I believe that the experience of having an image is just the inner aspect of a readiness to perceive the imagined object, and that differences in the nature and quality of people's images reflect differences in the kind of information they are prepared to pick up. Some people find it natural to say they "see" their images, while others reject this terminology altogether. It is hard to know how much these individual differences are due to accidental choices of metaphor and how much they reflect real differences among people's visual systems. If images are instances of perceptual readiness, however, one would certainly expect to find differences in the accuracy, scope, and detail of the information they anticipate. (Neisser 1976:130-131)

Boulding (1956:7-13) suggests other features of the processing of information in relation to images. He states that when information is received from the world, one of four things happens. Either (1) the existing image is unaffected, or (2) it is changed in a regular and well-defined way, or (3) the structure of the image changes in a radical way, or (4) the image is clarified or made more certain (or the reverse). He emphasizes the role of values in this process. He suggests that value scales constitute "perhaps the most important single element determining the effect of the messages [an individual or organization] receives on its image of the world." A message that is value-neutral has little or no effect on the image, but a message that either supports or is hostile to the individual's value system makes a greater impact. Favourable messages may lead to minor changes in an image, such as by simple addition, or they may increase the stability of the image and heighten its resistance to unfavourable messages. If a message is contrary to a value held, it will be resisted. Such resistance may amount to ignoring the message, or it may be displayed as an emotional response such as anger or indignation. There is a limit to the strength of such resistance, however.

This resistance is not usually infinite. An often repeated message or a message which comes with unusual force or authority is able to penetrate the resistance and will be able to alter the image. (Boulding 1956:12)

Boulding suggests, though, that the power of value systems in enabling either the maintenance of or alterations to images should not be underestimated. Even simple sense data, he says, are

mediated through a highly learned process of interpretation and acceptance. (...) Indeed, we only get along in the world because we persistently disbelieve the plain evidence of our senses. (1956:14)

Thus to the individual there are no such things as facts: "there are only messages filtered through a changeable value system" (1956:14). Boulding refers to this as an organic theory of knowledge. Basic to his model, of course, is a notion of the origin of the value systems the individual possesses. These, he says, are created in various ways: by ceremonial and formal instruction; by face-to-face groups, especially the individual's peers and family; by charismatic individuals; and others.

Gordon also discusses the modification of images, and the processes involved. He suggests that a person's imagery may be fixed and rigid or fluid and flexible.

(If it is rigid) the world tends to be furnished with objects and experiences that date far back into his past; because they remain relatively uncontaminated by later events they are often essentially oversimplified, stereotyped or even quite out-of-date. But if flexibility is extreme there may be a quality of rootlessness and so all in such a world may come to seem insufficiently defined. (1972:65-67)

Gordon further suggests that this set of features may relate to tendencies toward convergent and divergent thinking.

The individual tendencies described by Gordon, and the issue of resistance discussed by Boulding, may account for some of the differences in the degree to which initial images were retained by the student nurses in this study. As has been mentioned earlier, some students' images altered little despite experiences that contradicted them. They retained their initial images by believing that the contrary experiences they had encountered so far were not representative of real nursing (i.e. the nursing of their images), and that experiences that would match their images still awaited them. Other students no longer recalled their initial images when interviewed after several months of clinical nursing experience. One student was not even able to recognize her initial image when her own words from her first interview were repeated to her. Thus there seemed to be a wide range of susceptibility and resistance to image alteration, among the students interviewed.

Eliciting Data on Images

Doob (1972:312) has noted that "images can be observed directly only by each person within himself." Not only is imagery private, but, as Gordon points out, it is pervasive.

It is this pervasiveness which makes it that imagery is so secretly ever-present and which makes introspection so exceedingly difficult. Indeed no one can ever be fully aware of all the images that are activated in his mind at any particular time and in any particular situation. (1972:67)

Given the above statements, which are hard to dispute, the study of mental images is problematic. How can the researcher gain access to images to study them? It seems clear that images form part of the individual's phenomenal world (Gibson & Olum 1960:312). Merleau-Ponty has said that "the sensations and images which should be the beginning and end of all knowledge never make their appearance anywhere other than within a horizon of meaning" (1962:15); the meaning must be imputed by the individual. The evidence for an image is therefore directly available only to the individual experiencing the image. Thus the researcher must rely on indirect evidence. Doob suggests that there are two choices in this regard: either to investigate reported images or to investigate inferred images.

In an experiment or investigation images are reported when they are mentioned or described verbally by the subjects experiencing them; they are inferred by the experimenter or investigator either from the stimulus

materials or from the observable responses of the subjects. (Doob 1972:312)

In the present study, the second of these choices is inappropriate to the nature of the images being explored, and the first method is the chosen one. Neither Horowitz nor Morris and Hampson entertain the second option. Horowitz indicates that “(a)n image is such a private experience that there is only one primary source of information about it: the introspective report” (1978:5). Morris and Hampson state that “(t)o obtain information about someone else’s mental images we have to rely upon their descriptions of their experiences” (1983:25).

There are obvious problems with relying on respondents’ reports of introspection on their intrapsychic images. Since the subjects alone have access to the images being reported on, questions of reliability arise. Behaviourists would therefore say that such images are unavailable for scientific examination. Morris and Hampson suggest that the dubiety regarding reliability is not sufficient cause to reject introspection.

Something is better than nothing, and the alternative is to dismiss conscious experience as being completely unsuitable for study. (...) It is usually possible to limit the likelihood of error. (...) It is worth remembering that the reliability of data is a matter of degree. In the last analysis all reports of empirical results are open to doubt and deception or error. (1983:29)

Horowitz accepts that research has shown introspective reports to be fragile. She acknowledges that it is possible that people fabricate or omit material, change reports to suit motives, “use terms that do not have shared meanings, forget, contradict themselves, distort experiences”, and make changes in experience. She indicates, however, that the researcher should not be overly dismayed by such risks, while at the same time should not accept image reports uncritically (1978:5).

Morris and Hampson recount the possibility that the very act of introspection may “interfere with the processes being introspected upon, and change them to the point of making the report on them worthless” (1983:28). They go on to say, however, that it makes no sense to reject the use of introspection on this basis, and yet to accept the results of decision tasks, as psychological researchers routinely do. These tasks, they point out, also “incorporate a potentially interfering response with the decision whose latency is being measured” (1983:29). Indeed, it might be argued that introspection followed by description might be more reliable than the results of decision tasks, as it makes use of the subject’s own words, rather than relying on those forced upon him by the researcher.

That there are limitations on introspection must be accepted. Morris and Hampson suggest that the language used may be one such limiting factor, in particular the

subject's ability to report in a language that will be understood with equivalence by the researcher. Another is the accuracy of recall, including the subject's state at the time the material was being encoded. This factor is not at issue in the present study, as it is not the accuracy of recalled reality that is of concern, but the subject's report of the image that she/he possesses. Another potential problem is the decision of whether or not to question the subject. Accuracy is highest with free narrative, since questioning may bias a report, but free narrative risks the possibility of material being omitted. Finally, the very act of paying attention to the image may interfere with and alter the report of it (1983:32-35).

Rather than rejecting introspection because of its potential unreliability, Morris and Hampson suggest meeting five conditions to maximize the accuracy of subjective reports:

- 1 The report should be possible in ordinary language or in terms that can be easily taught.
- 2 The report should be made as soon as possible after the experience which is being reported.
- 3 Demand characteristics should be minimized by avoiding direct questioning whenever possible, by making any questions as neutral as possible, and by not communicating the purpose of the experiment through a transparent experimental design.
- 4 The subjects should clearly understand that they are being asked to report their experiences, and not to speculate on how they understood the given tasks.
- 5 Subjects should be aware that they may not have any relevant experiences to report, and that this is not a failing on their part.

(1983:35)

This set of conditions is of limited relevance to the present study, as it assumes a different style of research design, but some of the items are of interest. The first is useful advice, though it was not a particular problem in the study, and whenever there was doubt as to a meaning, clarification was sought from the subject. The second was not relevant. The third was partially relevant, and was tackled by conducting interviews in an informal, minimally structured style. The fourth was not relevant. The fifth was relevant if experience is interpreted broadly to include the experience of an image.

Morris and Hampson also address the philosophical objections to introspection advanced by Ryle and Wittgenstein, but they do not accept them. Ryle (1949:232-35) argued for the inappropriateness of trying to study people's mental images, as they are not real in the sense that actually seeing is real. Morris and Hampson indicate that Ryle's argument comes to nothing, and point out that his own discussion of the

question contains the implicit assumption of the existence of images. Similarly they do not believe there is any weight in Wittgenstein's view that it is impossible to report on private objects such as mental images because such a report would entail use of a private language (1983:36-39). Wittgenstein (1953:264-65) seems to see the idea of private language as oxymoronic, since he states that language to be such must have publicly checkable rules. It might be suggested that Wittgenstein's argument against private language would be equally applicable to any language, since individuals often use language in private ways in relation to many more aspects of communication than just the reporting of mental images. Morris and Hampson make the point that use of words is in fact publicly checkable (1983:40), to which might be added the observation that otherwise people could never communicate anything successfully, let alone research on introspection.

In the present study, reports on introspection were considered to be the only way to gain access to the data required. The difficulties and dangers mentioned above were accepted as necessary risks, and efforts were made to minimize the resulting potential for bias and unreliability.

Chapter 2

SOURCES OF OCCUPATIONAL IMAGE

Student nurses as they enter training must have some mental image of what nursing is and what nurses do. In this sense, their occupational socialization has started before they enter nursing. De Fleur has described this as occurring “largely through accidental or haphazard exposure to a variety of learning sources” (1964:57). As a result, as Chaska has said,

...the new recruit to nursing who appears for the first day in class already has more or less well-established notions of what it means to be a nurse. These attitudes and expectations necessarily influence how the student receives and responds to that which is encountered after entering the school. (1978:12)

After entry, the student’s image begins to be further revised as a result of exposure to the world of nursing. The moment of entry might be seen as a turning point in the image’s development. The study reported in this thesis explores the image at that critical episode and then examines the processes of change that follow. The discussion in this chapter considers two particular factors that may have helped shape the pre-entry image, that is, literature and television aimed at children and young people.

In nursing, considerable attention has been given in recent years to the perceived problem of nursing’s image. It is not the intention here to provide a detailed exploration of the public image of nursing; this has been done at great length by others, to such an extent that it has become virtually a cliché. It is mentioned only as it is relevant to the discussion, the purpose of which is to provide a backdrop for the study which is reported in the following chapters. Its focus is on potential sources of the image rather than on issues of recruitment.

Lay Literature for Young People 1: Children

An informal investigation of literature available at one Scottish public library system and two popular bookshop chains revealed two types of books that might influence a child’s development of an image of nursing.

For very young children, one type that may make an early impression includes books intended to prepare a child for admission to hospital. Simple features of image are evident in such books: nurses work in hospital; most nurses are female (doctors are usually male); nurses wear uniforms with caps; nurses smile and help you feel better (e.g. Butler 1990).

Nurses sometimes appear in fiction books for young children as well, though often these characters are not registered nurses. *Nurse Matilda* (Brand 1964), for example, is a children's nurse or nanny.

Lay Literature for Young People 2: Teenagers

CAREERS MATERIAL

For teenagers, a variety of careers-related literature is available. A number of books in this category were reviewed in an earlier study (Kiger 1984), and most of the same items remain available in local libraries or bookshops at the present time. Characteristics of nursing as portrayed in these include working with people, variety of work experiences, the centrality of caring, high social value, hard work, and encounters with suffering. Desired qualities of the nurse are depicted as responsibility, compassion, common sense, ability to cope without flapping, physical fitness, air of authority, ability to know when to sympathize and when to "stand no nonsense" (King 1974), and ability to put personal needs to one side. One of the problems with such materials is that although they portray a picture which may have been realistic at the time of their publication, many of them are now out-of-date.

One book which has been up-dated is Clark's *Careers in Nursing and Allied Professions* (4th edition, 1989). Despite a number of minor errors, or facts which are true only in England but are presented as UK-wide, this publication provides a fairly balanced view of what nursing entails and what the training consists of. It presents an up-dated account of a typical student nurse's day, showing her giving total patient care rather than doing tasks. It offers a selection of personal views of individual students and qualified nurses, including some of the negative aspects as well as the positive ones — unsocial hours, understaffing, the stress of changing wards, low pay.

A number of other publications new since the earlier survey are also available, and they display varying approaches to the issue.

Waring's *Becoming a Nurse* is in many ways traditional in its attempt to appeal to young people. It stresses, for example, the traditional view of the uniform:

The crisp new starched material that never seems to fit quite properly, the brand new regulation lace-up shoes, the fob watch hanging proudly from breast pocket, and the hair (...) tied neatly back under a new white cap ... (1986:14)

This description is similar to that found in popular fiction. Sitting oddly beside it is a statement with quite a different tone: "The highlight of these few weeks is the first pay cheque" (Waring 1986:15).

Waring's book is designed to inform the interested young person of what lies in store once nurse training commences. Overall it describes general nurse training, though this is not specified. It gives details of the process of entry, the introductory course, and early experiences in different types of wards. It does this quite successfully, though a number of criticisms can be made. Value judgements abound in places. Some statements are anachronistic for the publication date, such as the statement that "Most training schools prefer their students to 'live in'" and the use of the designation "mental subnormality nurses". Some information provided is true only of England, though the book purports to be about nursing in Scotland, Northern Ireland and Wales as well: intake groups are referred to as "sets"; systems of internal night rotation are presented as the norm; and the examination system described is English, to name a few examples. The reader gains the impression that the author, a clinical teacher, has generalized from a competent knowledge of one type of training in one area in England.

On the positive side, Waring offers an informative and realistic account of many aspects of a student's training. For example, the impact of working shifts is well described. There is a balanced discussion of the nurse's response to caring for the dying, though the description of the support given to students in this regard is perhaps unrealistically idealistic.

Quite a different perspective on nursing is offered in *Timeline: Nursing* (Holley 1989). Its author is a historian, not a nurse. This book contains an interesting account of the history of nursing, with a view of the present-day profession. There is much use of contemporary source material, some of which is primary, including some particularly colourful quotations and some pictorial material. The text is well-balanced overall and avoids value judgements for the most part, alluding to some of the debatable issues in thought-provoking questions for discussion rather than making statements about them. There are a few minor inaccuracies or oversights, but these do not seriously mar the quality of the book.

The Careers and Occupational Information Centre's publication *Working in Nursing* (1989) offers yet another type of information source for young people. It is more professional in tone, stressing education standards, promotion and specialization opportunities, research, and management. It gives an idea of what goes on in various types of clinical areas, but unlike many other publications, the descriptions come across as matter-of-fact, with little emotional overlay and strong emphasis on intelligence, skills and responsibility and less flavour of dedication and selflessness. Interestingly, the nurse's uniform still appears to have a high profile in the illustrations, with frilly caps, stripes, belts, and silver buckles much in evidence. In common with many such publications, this one purports to be relevant "whether you live in Aberdeen,

Humberside or South Devon”, but in fact it has a very English perspective, basing nearly all its text on courses and clinical examples from the southeast of England.

There are a number of comprehensive careers guides for young people to consult in the libraries. One such is *Jobfile 89—The Comprehensive Careers Handbook* (Miller *et al* 1988). It contains an entry for “Nurse—Registered, RGN (First Level)”. It describes the work of the nurse:

Looks after patients, particularly assisting with their medical treatment. Has responsibility for general condition of patients. Gives medicines/injections, removes stitches & assists with transfusions & at operations. Writes reports, accompanies doctor on ward rounds. Does simpler nursing tasks too – making beds, feeding patients etc. Can specialize eg children.

This appears an unbalanced view of a nurse’s work, with the emphasis on technical, administrative and doctor-dependent tasks, and little mention of what might be thought of as basic nursing care. It is also mildly inaccurate, implying that paediatric nursing is a specialty of general nursing. This account is followed by an indication of the school qualifications required for entry in the four countries of the UK. It then cites the following as necessary skills:

Calm nature, able to take responsibility, must not be squeamish, perceptive, good general fitness, efficient, able to understand other people’s problems, not quick tempered, sympathetic, reassuring, patience, able to work in a team.

This (grammatically inconsistent) list notably lacks any mention of a need for intelligence. There follows a long list of diverse “Notes” which range from “Work would require coping with the sight of blood” to “You would be helping people, meeting a lot of people.” Again there is no indication of a need to be intelligent, though it is stated that “Study after school (is) essential, for professional qualification.” With regard to “Entry”, it is stated that “Hospitals vary in their requirements”, which implies that entry to nursing is entry to employment rather than to an educational pursuit.

Another comprehensive source of career information is *The Student Book 1992* (Boehm and Lees-Spalding 1991). This publication offers an up-to-date set of details about entry requirements for nursing and where to obtain application information. It also includes a short article on “Nursing Studies” written by a Professor of Nursing Studies at a Scottish university (Prophit 1991). This article gives a flavour of the ethos of present-day nursing and a thumbnail sketch of the variety nursing work comprises, as well as advice about nursing education opportunities.

Each of these publications has the potential to influence the formation of a young person’s image of nursing. It could be assumed that the young person would be aware

of the resulting image development, since such literature would be deliberately sought out. Fictional literature, on the other hand, might be assumed to have a subtler influence.

FICTION

An interesting discovery in relation to fiction for teenagers was the popularity of the oldies-but-goodies. The oldest of these is the *Sue Barton* series (Boylston, from 1939). These continue to be popular despite their age and provenance (American). The computerized records from one children's library indicate that each copy is lent out approximately six times per year. The cover designs in the more recent paperback printings have been modernized, otherwise they are unchanged from the original editions. However, elements of the stories in this series are surprisingly up-to-date. For example, there is evidence of patient assignment rather than task allocation in the accounts of Sue's experience as a student (Boylston 1939). The *Sue Barton* series is not in print in the UK at the time of writing, but it has been reprinted numerous times and will doubtless undergo further printings. *Sue Barton Senior Nurse*, for example, had its 14th British impression in paperback by Knight Books in 1984, *Sue Barton Visiting Nurse* its 10th in 1982, and *Sue Barton Rural Nurse* its 11th in 1981.

A number of books from another American series, *Cherry Ames* (Wells, from 1943), are still available but not as popular as Sue Barton. The books in this series tend to be less well written and less about nursing itself, as well as having a number of errors of detail (such as that Cherry has an "identical twin" who is not only fair-haired while she is dark, but is male).

A British series that currently outdoes both *Sue Barton* and *Cherry Ames* in popularity in the children's libraries is the *St Mark's* series (White, from 1958). Taking two of the books as examples, a single copy of *Nurse at St Mark's* was borrowed from one library 21 times during the two years prior to August 1991, and a single copy of *Staff Nurse at St Mark's* was borrowed 15 times during the same period. Again, this series is old, and is in some ways more out-of-date than *Sue Barton*, particularly in relation to the types of tasks student nurses are described as doing and the way their assignments are given out. The nursing element in the stories is a strong focus, and was probably fairly realistic in its time, though there is also a strong focus on family events and romance.

A number of elements that are common to these nurse series can be shown by examples from the *St Mark's* books. Uniforms are a powerful symbol, and Joanna wears a "crisp nurse's uniform" (White 1963:122) and has "honey-coloured hair showing under her starched white cap" (White 1966:7). The reader knows Joanna is

privy to the secrets of nursing from the inside through her understanding of and participation in the rituals:

They joined the orderly drift from the tables (in the staff dining room), small knots of nurses gathering in the corridors and on the stairs as St Mark's ritual demanded, each group entering its own ward together. (White 1963:54)

At seven-fifteen sharp the doors of the ward were thrown open and the evening visitors came streaming in. They carried bunches of flowers, and fruit netted in string bags; clean laundry bulged from brown-paper parcels or lay hidden discreetly in suitcases. Those who had not been before tiptoed in timidly, seeking direction, but the regulars walked in confidently to the familiar bedsides. (White 1963:96)

Certain elements of received wisdom are made clear, as when Joanna avoids excessive involvement, even in response to an individual patient's needs.

Joanna purposely made one or two other stops on her way down the ward. Concerned as she was about Samantha, it would not be wise to let her think herself more important than other patients. (White 1966: 66)

It is especially evident in all the books in the series that for a young woman, even one seriously dedicated to nursing, her career must take an inferior place once she is married or even just engaged. Her husband's or fiancé's career must be her primary concern (particularly if he is a doctor), and if she has children she will stop working outside the home until they have grown up.

There has been no similar series published in more recent times to replace these still-popular but out-dated series. There have been several publications based on television programmes, but they do not seem to achieve the same degree of popularity, perhaps because interest in them may not outlast the lifetime of the TV series. These have included books based on *Angels* (e.g. Milne & Duxbury 1975, Georgeson 1979), a series of the 1970s and early 1980s. It was of the soap opera variety and followed events in the lives of a number of students and staff nurses. The books tend to have little about nursing, and a great deal about romance and sexual affairs. A more recent example is the Granada series *Children's Ward*, from which two books have so far been published (White 1990 & 1991). These are more about the exploits of patients and their friends than about nurses.

One difference between the TV-based books and the *Sue Barton/Cherry Ames/St Luke's* type is that they do not have a central nurse character whose life provides the main focus of the stories; instead they have a collection of more-or-less equally starring characters and a multitude of plot lines. In addition, the nurses are not portrayed as having the same degree of dedication and selflessness, and tend to be more likely than

Sue, Cherry or Joanna to display faults. This may seem at first glance to imply a preferable degree of realism, but a second look reveals that the problems and complications portrayed are probably no nearer to real life than are the thoroughly admirable qualities displayed by the nurses in the earlier style books. They are simply unreal (or super-real) in a different direction. As a general comment, it might also be said that the writing is of a poorer literary quality than the *Sue Barton* and *St Luke's* series. This is perhaps inevitable, since they are merely accounts of stories produced for another medium, rather than having been produced as literature, whereas the earlier series were written solely as books.

It is unlikely, of course, that teenagers restrict their reading to books designed for their age group. Many are no doubt exposed to nurse characters in various types of adult fiction. Such literature was not surveyed for the present study, as its extent and diversity mean that an informal survey could not provide a representative picture of the images portrayed. A number of writers have studied such literature. These include: Ver Steeg who looked at the fictional nurse in "category novels", that is, "formula stories with stereotyped characters and a standardized plot" (1968:21); Richter and Richter (1974) who explored the way nurses are portrayed in fiction; Kalisch and Kalisch (1983) who investigated the influence of authorship on how the image of the nurse is portrayed in novels; and Melosh (1988) who looked at how the relationships between nurses and patients are presented in twentieth-century short stories.

Nursing critics of existing literature often suggest that the old images need to be done away with completely, but this is arguably an extreme view. If one were to reject all literature that portrayed out-dated images of occupational groups, much worthwhile and enjoyable reading (including many classics) would be lost. It would be reasonable to suggest, though, that there is a vacant literary niche for an up-to-date series of well-written books based around a nurse heroine, one with enough idealism to be admirable but enough human frailty to be believable, and set in a realistic modern nursing context.

Professional Recruiting Literature

A variety of recruiting literature is available from nursing colleges and from central sources. Three widely available brochures from the past decade are considered here, with particular reference to general nursing.

The booklet entitled *Nursing* published by the Department of Health and Social Security provides the first example. Its introduction offers a potted (and only dubiously accurate) version of the history of modern nursing, and outlines the qualities a nurse needs, of which there are four:

You need to be bright. (...) You need to be independent. (...) On the other hand, you also have to be able to work with others. (...) Last but not least, you need a good sense of humour. (DHSS 1983:3)

The information given about general nursing has a clear illness orientation. High-technology nursing is described, with no reference to any psychosocial element to the work of the Registered General Nurse (RGN) apart from a comment that “immense tact” is needed in dealing with the family of a person severely injured in a car accident. Objectivity and paperwork are emphasized. Following descriptions of the work of nurses in the other major branches of nursing, details are given of the qualifications and training required. In a section for “Mature Applicants”, the uncompromising requirements of the occupation are stressed:

If you have young children, be sure you can make adequate provision for them and be prepared to discuss it at your interview, because as a student or qualified nurse, mature or not, you can expect no special treatment. (DHSS 1983:21)

In the final section of the booklet, the following is offered:

To summarise. Nurses are not the handmaidens of the physicians. Mindless routine is not the order of the day. Taking a temperature is not the biggest intellectual challenge you'll ever face. A patient's gratitude is not the only reward of the job. Nor is the work of the general nurse more demanding nor more important than the work of those who nurse the mentally ill or nurse people with a mental handicap.

Nursing is not a static profession.

It requires people who are able to question accepted customs and practice, create new initiatives and establish scientific principles.

In fact, this is not a summary, because many of the points covered have not been alluded to earlier in the booklet. The most curious feature of this section is its insistence on telling the reader what nursing is *not* without ever saying what it *is*. A final comment about this publication is that it contains many grammatical errors which impair the general impression it gives the reader.

Grammar is also a problem in the second example, a booklet that was available from the Scottish Health Service Centre entitled “*It's knowing that you're doing something to help*” (Scottish Health Service Management Development Group of the Common Services Agency 1986). In one major respect it differs from the DHSS publication discussed above, in that it contains a greater emphasis on health as distinct from illness. The section describing general nursing begins by indicating the variety of settings in which general nurses work. It then alludes to the dramatic nature of media portrayals of nursing, which it does not disagree with:

You will gain experience and become efficient in the use of machines and equipment used in the care of patients. This results in a high degree

of technical skill ... but this alone is not nursing. Writing in 1859, Florence Nightingale said “unnecessary noise, then, is the most cruel absence of care which can be inflicted on the sick or unwell.” This is still true today and at an early stage you will discover just how important adequate rest and sleep, made possible by peaceful surroundings, are to your patients’ recovery.

One wonders, given the plethora of potential quotes available from Nightingale, why the single quote selected to illustrate that not all nursing is technical focuses only on the need to protect the patient from excess noise.

The booklet goes on to stress that “nursing is more than just a series of tasks”, and the following aspects are highlighted: the assessment of patients’ needs; being part of a team; the importance of records; the theoretical basis of nursing; the importance of patient teaching; the fact that not all patients recover; the centrality of problem-solving techniques; the importance of communication skills; and the need to treat patients as individuals. There is a noticeable lack of information as to what hands-on nursing care consists of. The final section offers guidance to the candidate about preparing for interview, and its tone is less rigid than that of the DHSS booklet. It finishes by saying:

The interview is not an oral examination. It is an opportunity for people with a common interest to get to know one another.

The third example is from the material currently sent out by the Careers Information Service of the National Board for Nursing, Midwifery and Health Visiting for Scotland (NBS). It consists of a folder of pamphlets, collectively entitled *Nursing Opportunities in Scotland* [1991]. The pamphlet about general nursing is called *Working with People* (1990). Its content is virtually identical to the content of the booklet described immediately above, so it similarly lacks any real idea of what the daily work of the nurse actually consists of.

Considering the professional recruiting material together with the careers material discussed earlier, it is interesting to note that throughout all the publications examined, there were a number of everyday nursing tasks that were never mentioned, tasks such as bathing and other aspects of hygiene, and assisting patients to get out of bed, walk or exercise.

Television Documentaries

During the period immediately prior to the commencement of the present study, a number of documentary series appeared on television and thus were available to influence viewers’ images of nursing. One of these was the six-part series *Nurses* shown on BBC2 in late 1986, which took, as described in *Radio Times*, “a wide-ranging look at

the stressful and dedicated profession of nursing” (Lyll 1986). The six episodes included: one in a medical ward, during which a patient died; one in which patients from a geriatric ward were taken for a day at the seaside; one looking at the work of a husband and wife who were both psychiatric nurses; one in midwifery, including labour and delivery; one showing the work of an incontinence nurse; and one in a casualty department. These programmes did not glamorize, unrealistically dramatize, or idealize nursing. The picture they portrayed was realistic, and showed a variety of types of nursing work.

A number of other documentary-type television programmes screened in recent years have given a view of nursing work, without focusing specifically on nursing. *Hospital Watch* on BBC and *Jimmy's* on ITV have offered a type of slice-of-life view of events and activities within hospitals, and nursing is often visible in the “story” (though barely so in a 1991 series of *Hospital Watch*). *Your Life in Their Hands* on BBC has presented programmes centred round dramatic procedures or advances in medicine, and occasionally an episode has some relation to nursing. Recently the BBC series *The Doctor* covered the life and work of a general practitioner in a rural area of England over a period of one year. Individual nurses, such as those in the local cottage hospital, provided part of the ongoing life in the background of the doctor’s life.

Television Fiction

Nurses and doctors have been popular character types in television fiction since the days of *Doctor Kildare* and *Doctor Finlay's Casebook*. Several series were or had recently been available to be seen during the period prior to the interviews for this study. One of these was *Angels*, which was mentioned above in relation to written fiction. Another was *Casualty*, which is similar in type in that it has many central characters and many plot lines, some of which carry on from episode to episode. A notable feature of this series is the role of Charlie, the male senior nurse, who is portrayed as a strong and caring character who has human problems of his own as well as dealing with those of others, both staff and patients.

Both *Angels* and *Casualty* could be loosely categorized as soap operas, though the standard of writing and acting is arguably of a higher standard than one finds in many programmes of that genre. There were other programmes unequivocally of that genre that could also be seen at that time, particularly on daytime television. These included *The Young Doctors* and *A Country Practice*, both of which are Australian productions. *The Young Doctors* especially is in the glamour-and-romance style, with little evidence of reality in its portrayal of either medicine or nursing. *A Country Practice* is rather more believable, in both story line and dialogue.

Since that time, at least two additional series have appeared. These include *Children's Ward*, which was mentioned above in relation to the books based on it. The other is *The Flying Doctors*, another Australian series. This series contains a collection of reasonably believable characters involved in a fairly atypical type of nursing and medical work. It appears to be a notch above the other Australian programmes mentioned in standard of writing and acting, on a par with *Casualty*.

Comment on Image Sources

The literature and television sources surveyed above constitute potential information input that may contribute to the development of student nurses' images of nursing prior to their entry to training. There are, of course, many other potential information sources. Family members and friends in nursing, information from careers teachers at school, recruiting material from colleges, contact with nurses either as patients or as visitors to hospital — any or all of these may play a part in the early formation and later modification of the individual's image of nursing.

As was mentioned in the previous chapter, the influence of incoming messages on an existing image will be affected by the individual's value system through which the messages are being filtered (Boulding 1956). It could be argued that such sources are also capable of playing a part in the formation of the value system itself. Thus it seems doubly useful to be aware of the content of such media when exploring student nurses' images of nursing.

PART 2

METHOD AND DESIGN

Chapter 3

METHODOLOGICAL ISSUES

In this chapter, the “generation of grounded theory” as described by Glaser and Strauss is discussed. A general discussion is followed by a consideration of the relevance of this approach to research in nursing and nursing education. The methodological techniques of comparative analysis and theoretical sampling are then explored, and the type of theory generated is considered. Finally, the use of interviewing in qualitative research is examined.

“Generation of Grounded Theory” as a Research Approach

In simple terms, Glaser and Strauss’s (1967) generation of grounded theory is a qualitative approach by which the researcher collects and analyses data with an open mind, looking for theory that will emerge from the data. It can be contrasted with research approaches in which the researcher collects and analyses data for the specific purpose of testing preconceived theory. The product of the process, that is, the grounded theory which is generated, “consists of a series of hypotheses linked together in such a way as to explain the phenomenon” (Stern 1980:21).

Duffy (1985:226-7) indicates that grounded theory is the prototype method at the phenomenological end of the research style continuum, contrasting it with the “true experiment” as the prototype at the positivist end. Grounded theorists, she says, “attempt to humanize the research process” and recognize the subjective nature of social participants.

Glaser and Strauss (1967:28) indicate that their approach is a method that offers the opportunity to discover theory from data obtained without the limitations imposed by a preconceived theoretical framework. They do not exclude verification from their process, but they stress that this should only be done with theory that has been grounded in data.

Approaching data with the intention of finding theory rather than testing theory has several advantages. The researcher is unlikely to have his perception narrowed by having the direction of his search predetermined, and is therefore more likely to see what is actually there, in its proper natural balance. The approach “promotes the development of theoretical accounts and explanations which conform closely to the situations being observed,” and the theories developed “are likely to be complex rather than over-simplified ways of accounting for a complex world” (Turner 1981:226-7). The researcher is open to discovering features that are new or unanticipated, and is likely to have a less biased view of those features that it might have been possible to

anticipate. Further, the researcher can avoid one of the hazards of the “scientific paper format” (Silverman 1985:2), that is, the imposition of meaning on social relations, arising from the researcher’s prior definitions of concepts and hypotheses, to the exclusion of the meaning perceived or intended by the participants themselves.

In common with other qualitative methods, the grounded theory approach generally calls for seeking data in the context of the real world. This approach thus avoids two features of the traditional positivist model which Mishler (1979) has described as being unsuited to social and behavioural research. Firstly, in the search for “universal context-free laws”, and through the use of “context-stripping methods”, Mishler says, the traditional model has ignored an essential feature of the social world, one which is easily understood by ordinary commonsense observation:

We rely on context to understand the behaviour and speech of others and to ensure that our own behaviour is understood, implicitly grounding our interpretations of motives and intentions in context. (1979:8)

It could therefore be argued that doing research on social or behavioural phenomena in isolation from their natural context is not to study the phenomena at all, but to study phenomena contrived by the research process itself. Glaser and Strauss’s method calls for collection of data from the world of the participants. They further recommend use of various kinds of data and techniques of data collection, providing different views of the phenomena under investigation (“slices of data”), thus filling out the emerging theory in a manner consistently grounded in data (Glaser & Strauss 1967:63-65).

A second feature of the traditional positivist model noted by Mishler (1979) as being inappropriate to social or behavioural research is the method of formulating theoretical aims in terms of “the search for general or universal laws which describe relationships between two variables.” He says that “standard theories and methods have all been directed at discovering laws of the form $Y = f(X)$.” The validity of research studies which thus attempt to reduce social phenomena to relationships between two variables could justifiably be questioned on the grounds that studying a single effect of a single variable, in isolation, cannot explain satisfactorily either the effect of the one or the cause of the other, as in the social world they occur amid a plethora of other variables.

Again, the approach recommended by Glaser and Strauss is in contrast with the positivist approach criticized by Mishler. Not only do grounded theorists recognize the existence of variables (often termed “categories” and their “properties”), they actively seek to identify them and discover their interrelationships, and do not cease their search, or at least do not consider it finished, until they are satisfied that the picture is

complete. The particular techniques employed in the implementation of this strategy are discussed below (see pages 35-43).

The grounded theory approach has a basis in symbolic interactionism. This perspective involves a recognition of the “peculiar and distinctive character of interaction as it takes place between human beings ... (who) interpret or ‘define’ each other’s actions instead of merely reacting to each other’s actions” (Blumer 1962:180). Responses are seen to depend on meanings attached to actions of others, and thus human interaction “is mediated by the use of symbols, by interpretation, or by ascertaining the meaning of one another’s actions” (Blumer 1962:181). Sharing this perspective, qualitative approaches such as the grounded theory approach “place the emphasis on an understanding of the data from the perspective of the subjects of the research” (Melia 1981b:699). This is in contrast to quantitative approaches, which systematically analyse data with the intention of being able to generalize or predict from conclusions based on interpretation of the data, often by statistical techniques.

It has been indicated that the grounded theory approach is generally seen as being located in the qualitative research camp. In addition, it is commonly viewed as an inductive strategy (e.g. Wilson 1977, Simms 1981, Johnson 1983, Duffy 1985). It is not the case, however, that the generation of grounded theory belongs exclusively within either of these categories. Grounded theorists may make use of quantitative as well as qualitative data, and they may employ deductive as well as inductive strategies.

Glaser and Strauss (1967) indicate that, although their method is primarily concerned with qualitative data, it is quite possible to derive theory inductively from quantitative data. In other words, theory can be generated from, and thus grounded in, quantitative data, if the data are approached without a preconceived theoretical framework (unless such framework itself is grounded in empirical data, rather than being speculative in origin).

It is also the case that a grounded theorist may make use of statistical techniques at some point in the process, as Simms (1981) did when evaluating propositions developed from interview data on “a work-study theory of preference for off-campus study.” Stern *et al* (1984:373), in fact, indicate that the grounded theory approach “bring(s) together the two worlds of research, qualitative and quantitative,” and say that this allows a “clearer representation of reality (to) be gained” than would be possible by either method alone.

It might be argued, however, that the inclusion or use of quantitative data and the use of quantitative techniques of handling data do not necessarily preclude the possibility of a researcher’s maintaining a perspective that is qualitative in character. That is, the researcher may approach quantitative data with an open mind, with the intention of

finding theory rather than testing it. This being so, it seems reasonable to locate the grounded theory approach well towards the qualitative end of the continuum.

The inductive nature of Glaser and Strauss's method is also not absolute. During the process of theory generation, deduction is employed in the verification of the emerging theory, and it provides the direction for further sampling. It is also acceptable to make use of previous theory deductively, as long as that theory was originally grounded in empirical data. Thus their method involves both inductive and deductive thinking. However, Glaser and Strauss (1967:30) are firm in their insistence that the origins of theory must be inductively derived, suggesting that theory is likely to be better "to the degree that it has been inductively developed from social research."

In emphasis, then, Glaser and Strauss's method for the generation of grounded theory is qualitative and inductive, and is directed towards discovering rather than testing theory. Its practitioners gather data in the world, acknowledging the subjective nature of social participants, and the significance of the context in which social phenomena occur. This method seeks to discover in full the multitude of variables that relate to the phenomenon under study, by obtaining data from a variety of views, and by continuing to gather it until new evidence ceases to emerge. Analysis of the data leads to the generation of theory. Such theory is then available for testing, if this is desired, and for use by other grounded theorists working in similar areas of the world.

The Relevance of Grounded Theory to Research in Nursing and Nursing Education

The grounded theory approach, in common with other qualitative research methods, once suffered as a result of the emphasis on rigorously scientific and "objective" research methods, by being largely ignored by most nursing researchers. This can no longer be said to be the case. In recent years, a growing body of research has been produced using qualitative principles, and a considerable proportion of this has employed the approach expounded by Glaser and Strauss. This will become evident in later discussion within this chapter.

Spencer (1983) makes the point that a characteristic feature of humans is the ability to contemplate our own subjectivity, and that nursing researchers should keep this in mind when selecting methods. Further to Spencer's point, it could be argued that employing a qualitative approach allows the researcher to acknowledge without guilt the doubly subjective nature of the research process employed — that is, the subjective influence of the individual subjects of the study, and the subjective influence of the researcher. The researcher who is not under an obligation to strive to maintain total

objectivity does not run the risk of claiming to do so in the presence of unrecognized or unacknowledged subjective influences in her/his work.

It seems likely, then, that many research problems in nursing and nursing education can appropriately be tackled with qualitative methods. Melia indicates this when she states that

there is an elusive element in nursing which cannot be observed; this element has to do with the caring aspect of the work. The unseen reasons for certain nursing actions, the almost instinctive parts of a nurse's role which are incorporated unwittingly into the nurse's work pattern; these are amenable to a qualitative research approach.
(1981b:199)

The substantive area of nursing practice is thus perhaps ideally suited to a grounded theory approach. As Wilson (1977) has pointed out, it is a process-oriented method, and "processes are the life of nursing practice." The same point could be suggested in relation to nursing education, where processes and human interactions are also at the centre of practice.

Several researchers in nursing have made the point that the present state of nursing knowledge and theory makes the generation of theory a more relevant research activity than the verification of theory. Duffy has spoken of the "need for nurse researchers to generate nursing theory before prematurely attempting to verify theory, theory not developed in nursing contexts and which may be meaningless" (1985:231). Field and Morse (1985) believe that the grounded theory approach, originally developed for sociological research, has utility for nursing research. They believe that more attention in nursing needs to be paid "to the development of concepts and the reality of the context in which they occur." This fits with the view of Stern, who thinks that "the strongest case for the use of grounded theory is in investigations of relatively uncharted waters, or to gain a fresh perspective in a familiar situation" (1980:20).

Research in nursing education in Britain, particularly in the National Health Service nursing school or college context, could be said to be in an analogous position. That is, nursing educational practice has been based primarily on tradition and intuition until the present era of upheaval and change, as basic courses move into the higher education sector as diploma courses. Thus there is as yet an inadequate body of research upon which to base many of the vital decisions that are being made in the development of new curricula.

Comparative Analysis and Theoretical Sampling

At the core of the grounded theory approach are the methodological techniques of comparative analysis and theoretical sampling. In order to explain how these are employed,

it might be useful first to consider how the grounded theorist approaches the beginning of a study.

An essential feature at the start of a grounded theory study is that it be approached with an open mind. As Duffy says:

Sampling in grounded theory eschews a preconceived theoretical framework. The researcher begins with some general subject awareness and looks to the study to be sensitized to the concepts. (1985:227)

Stern actually goes so far as to suggest that literature relevant to the topic under study should not be investigated at all beforehand, for three reasons:

(1) the search may lead to prejudgement and effect premature closure of ideas and research inquiry; (2) the direction may be wrong; and (3) the available data or materials used may be inaccurate. (1985:153)

Following these ideas strictly would seem to be difficult, since the researcher is bound to have done some reading around his subject area while focusing on the problem to be studied. In addition, it is perhaps not entirely in line with the concerns of Glaser and Strauss. Their reservations as to the use of already-existing theory apply not to all previous theory, but to theory that is not grounded in data, that is, theory that has been developed in isolation from experience in the real world. Strauss (1970) has indicated the legitimacy, within the grounded theory approach, of building on previous theory. He suggests that it is appropriate to fill in gaps in extant theory, extend its scope, or supplement it, as long as this theory is grounded in experience rather than speculation.

There are several examples of grounded theorists who have effectively employed such a process. Glaser and Strauss themselves have built on previous theory of their own. For example, they followed their research into *Awareness of Dying* (1965a) with work that led to a higher level of abstraction of their theory in *Status Passage* (1971). Other researchers, too, have carried out studies which extend Glaser and Strauss's 1966 work on awareness of dying. In some of these studies (Quint 1967, Hurley 1977, Atwood 1977), the focus was an extension from the patient's perspective of the dying experience into the professional carer's perspective. In others, the study was in a related area, such as the experience of pain (Fagerhaugh 1974, Weiner 1975, Fagerhaugh & Strauss 1977).

Other examples of building on grounded theory include Dingwall and Murray's (1983) extension of work by Jeffery (1979) on the categorization of patients by staff in accident and emergency departments, and Luker's (1984) use of Melia's (1981a) work on student nurses' perceptions of their training, as background to her study of the perceptions of degree course student nurses.

Once the grounded theorist has selected an area for study, the principles of theoretical sampling and comparative analysis immediately become relevant. The exact point at which preparation ceases and data collection begins seems to be one point in Glaser and Strauss's recommended approach about which guidance is missing or vague. There is reasonably clear guidance as to what not to do, and what is appropriate to do, in the preparation; there is a great deal written about how to deal with the data once data collection has commenced; but the guidance about commencing with data collection is ambiguous. As data accumulate and are analysed, theoretical sampling techniques (described in detail below) give direction to the data collection. If, however, theory were used to guide the initial collection in a fresh area of study, surely this would not fit with Glaser and Strauss's basic tenet of grounding all theory in data; no theory could have emerged from data not yet collected. Most researchers writing on the generation of grounded theory make vague mention of this initial step, as Turner does in commencing his discussion of the nine steps he has extracted from Glaser and Strauss's description of their method. Turner says that in Stage 1, "the researcher is presumed to have carried out a certain amount of fieldwork, and to have collected some data, typically in the form of transcribed tape-recordings, or field-notes" (1981:231-2). Glaser and Strauss (1967:45) themselves state 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."

Recent writings do not clear up the problem. Strauss and Corbin, for example, state:

... if you begin with a list of already identified variables (categories), they may — and are indeed very likely to — get in the way of discovery. Also, in grounded theory studies, you want to explain phenomena in light of the theoretical framework that evolves during the research itself; thus you do not want to be constrained by having to adhere to a previously developed theory that may or may not apply to the area under investigation. (...) it makes no sense to start with "received" theories or variables (categories) because these are likely to inhibit the development of new theoretical formulations ... (1990:49)

However, when discussing "theoretical sensitivity", which they indicate is central to a grounded theory approach, they state that one of its sources "is **literature**, which includes readings on theory, research, and documents ... of various kinds" (Strauss & Corbin 1990:42). One might at first assume that they are referring to reading which takes place after data collection has begun, but this turns out not to be the case. They later state:

You can use the literature to derive a list of questions that you want to ask of your respondents or that guide your initial observations. This list

may change after the first interviews or observations, but it can help you get started on your research ... (Strauss & Corbin 1990:52)

They further say that “**(k)nowledge of philosophic writings and existing theories** can also provide ways of approaching and interpreting data” (Strauss & Corbin 1990:51).

The researcher who follows the guidance offered in these latter statements would seem to be entering the field with potential categories and theoretical frameworks very much in mind. This may be a problem if the researcher allows them to stop other categories and theoretical frameworks from emerging.

It seems clear that a compromise has to be made. In any case, it could be argued that it is virtually impossible for any researcher to enter a field that she/he has an interest in without any preconceptions at all. So perhaps the most sensible and practical way to approach the initial data collection is to accept a divergence from strict principle, take the initial plunge, and look for further guidance from the data obtained.

As soon as the first data have been obtained, the grounded theorist begins analysing it. The methodological technique of comparative analysis is immediately employed, and leads into the technique of theoretical sampling. Antle May provides a succinct description of this process:

The grounded theorist collects and analyses data simultaneously. Data are collected and recorded in such a way to permit close examination and comparison to other data. Such comparison yields natural groupings of data called categories. As fairly clear cut categories emerge, the researcher hypothesizes about possible connections or relationships between categories. Hypotheses that do not fit the data are dropped or revised, and new ones are continually developed. Eventually, categories and the relationships between them become sufficiently clear that a core category or process emerges. The researcher then searches for observations that substantiate or refute the hypotheses, a process known as theoretical sampling. (1980:447-8)

Thus, as soon as each piece of data is collected, it is compared with other pieces of data. Turner (1981:232) describes the initial evidence of emerging categories as “the tentative labelling of the phenomena which the researcher has perceived, and which he considers to be of potential relevance to the inquiry in hand.” Turner goes on to describe the way in which category labels which may initially be “long-winded, ungainly or fanciful”, and which may be at “any conceptual level which seems appropriate”, should be continually “changed and rechanged and adjusted” so that they continue to fit the data as they are collected and examined. In this way, the categories and their properties gradually become more and more clearly defined.

As themes begin to emerge, the researcher begins to use them to provide direction for subsequent data collection. This is the methodological technique of theoretical

sampling. The grounded theorist does not use statistical sampling — does not want to or need to. There is a purpose behind the selection of subjects or informants, and a statistical sample would be unlikely to answer that purpose. That is, the data collected from a statistical sample might not provide enough (or any) instances of the phenomena needed for comparison of emerging categories or properties, or relationships between them. And since the grounded theorist is not going to make claims about verity or universality, statistical sampling is not necessary. Wilson (1977:107) has offered a useful chart comparing the two sampling approaches (Figure 3.1). She explains how enrichment of emerging theory is brought about through theoretical sampling:

... by comparing similar groups, basic properties of a category are brought out. By comparing different groups, the boundaries of applicability of the theory can be established or its conceptual categories modified and broadened to increase its explanatory power. (1977:108)

Figure 3.1

Comparison of theoretical sampling and statistical sampling approaches

ITEM	THEORETICAL SAMPLING	STATISTICAL SAMPLING
Purpose	To discover concepts, hypotheses, and their interrelationships, i.e. theory; the magnitude of the relationships may be, but is not necessarily, part of the hypothesis.	To obtain accurate evidence on distributions of people among categories to be used in descriptions or verifications.
Adequacy	Judged on how wisely and diversely the analyst has chosen his groups for “saturating” categories according to the type of theory—formal or substantive—he wished to develop. <u>Inadequate</u> sampling is characterized by a theory that is thin and not well integrated and by many obvious, unexplained exceptions.	Judgment is based on techniques of random and stratified sampling used in relation to the social structure of a group or groups sampled.
Closure	Must be learned. Data collection for a grounded theory study stops when <u>new</u> categories and their related aspects stop appearing in the data.	Must continue with data collection until the predetermined sample size is achieved.

(Wilson 1977)

Although his sampling is done with purpose or direction in mind, the grounded theorist's approach to data collection continues to be open to new discoveries. Fagerhaugh and Strauss found this to be the case in pursuing data for their study on the *Politics of Pain Management*:

Lest the reader think that everything is strictly planned, we hasten to add that while sites and even the people interviewed are chosen with some care, a great deal is observed that is, happily, unanticipated. While the unexpected event can pertain to the verification of hypotheses, its more exciting function (...) is to suggest formulations not previously conceived. In our research, which began after considerable exploratory fieldwork, the happy accidents tended to relate the unexpected to what was already conceptualized. (1977:308)

It should be pointed out that the grounded theorist's subsequent data collection is not limited to that obtained from additional individuals by the same methods, but should extend to data collected by additional methods. Glaser and Strauss advocate this, saying that:

Different kinds of data give the analyst different views or vantage points from which to understand a category and to develop its properties; these different views we have called 'slices of data'. (1967:65-66)

They point out that the comparative analysis of slices of data is conducted in order to fill out the theoretical requirements of categories, not to fulfil any methodological requirements.

One of the characteristics of the grounded theory approach that is important to the analysis has to do with the dynamic nature of social phenomena. In addition, the researcher's investigation is dynamic. Glaser and Strauss indicate that their strategy of comparative analysis puts a

high emphasis on theory as process; that is, theory as an ever-developing entity, to be extended and modified, not as a perfected product merely to be negated. (1971:188)

Their view is that the "freezing" of theory by stating it in propositional form, does not reflect the real world. Their approach sees theory development as a process. The theory

evolves over time, and there is a vital, essential, and repeated interplay between gathering and analyzing data, which is directed in accordance with the evolving theory itself. (Fagerhaugh & Strauss 1977:309)

The view of theory as ever-developing does not necessitate a never-ending collection and comparison of data. As Melia describes it:

data are collected so long, and only so long, as they are adding to the development of a particular category. Once a situation is reached where nothing new is emerging, then the category is deemed to be saturated. (1982:329)

The sample is therefore not of a pre-determined size, but continues growing (as directed by the emerging theory) as long as new aspects are emerging, or while boundaries of, and relationships among, categories and properties are still being discovered. Sampling for each category can cease when that category is saturated, that is, when nothing new about it is emerging from the data, and the theory is well integrated (Duffy 1985).

There will, of course, be many categories, and not all will become saturated at the same time. In fact, if the researcher simply continued collecting data indefinitely, it is possible that new categories might continue to enter the scene at a rate faster than others became saturated. Such a procedure would clearly be impractical, and theory developed could become too unwieldy to be coherent, so it is necessary to have some guide as to when to cease pursuing categories, or which categories to pursue. Glaser and Strauss offer this advice:

The general idea is that the sociologist should sample a category until confident of its saturation, but there are qualifications. All categories are obviously not equally relevant, and so the depth of inquiry into each one should not be the same. Core theoretical categories, those with the most explanatory power, should be saturated as completely as possible (...) The sociologist should continue to saturate all categories until it is clear which are core categories. (1967:70-71)

Hence the researcher's own interpretation of the emerging theory leads to a recognition of which categories are crucial to the theory. Presumably, there is a matter of personal choice at work here as well, as the researcher decides which of various possible lines of theory to pursue from among those that might be available in the data. The researcher's own interest must to some extent determine such a choice.

Thus the techniques of comparative analysis and theoretical sampling are inextricably linked in the generation of grounded theory. Themes that emerge through comparisons of data provide direction for further sampling, and this sampling elicits further data to be analysed comparatively, and so on.

Several authors have offered an outline representation of Glaser and Strauss's strategy for generating grounded theory. Three of these are compared in Figure 3.2. Although there are clear similarities among the three outlines, it is obvious that each of these grounded theorists has interpreted Glaser and Strauss's approach slightly differently. Stern's (1985) view seems to reflect the perspective of Glaser and Strauss the least faithfully. The series of steps she suggests is more linear in form, and appears

to be more akin to traditional deductive methods. The outlines offered by Wilson (1977) and Turner (1981), on the other hand, seem more true to Glaser and Strauss's idea of simultaneous collection and analysis of data.

Figure 3.2

Steps in Glaser and Strauss's strategy for generating grounded theory, as outlined by three grounded theorists

Wilson (1977)	Turner (1981)	Stern (1985)
<ol style="list-style-type: none"> 1. Generating categories and their properties 2. Saturation of categories 3. Writing memos 4. Emergence of the core categories 5. Selective coding 6. Writing the theory 	<ol style="list-style-type: none"> 1. Develop categories 2. Saturate categories 3. Abstract definitions 4. Use the definitions 5. Exploit categories fully 6. Note, develop and follow up links between categories 7. Consider the conditions under which the links hold 8. Make connections, where relevant, to existing theory 9. Use extreme comparisons to the maximum to test emerging relationships 	<ol style="list-style-type: none"> 1. The prodrome <ol style="list-style-type: none"> a. Literature search b. Developing the research question c. Number of subjects 2. Collection of empirical data 3. Concept formation <ol style="list-style-type: none"> a. Coding b. Hypothesizing and categorizing 4. Concept development <ol style="list-style-type: none"> a. Reducing categories b. Selective sampling of the literature c. Selective sampling of the data d. Emergence of the core variable 5. Concept modification and integration <ol style="list-style-type: none"> a. Theoretical coding b. Memoing 6. Production of the research report

The question could be asked, of course, whether it is necessary, or perhaps even always desirable, to be true to Glaser and Strauss's ideas. Strauss's own views on this appear somewhat ambivalent:

One must **study**, not merely read, through the procedures as described in the various books and be prepared to follow them (Glaser, 1978; Glaser & Strauss, 1967; Strauss, 1987). (...) The procedures must be followed in doing research. (...) A certain amount of **openness** and **flexibility** are necessary in order to be able to adapt the procedures to different phenomenon and research situations.

(Strauss & Corbin 1990:26)

So it seems that one must follow the procedures *and* be flexible.

Throughout the preceding discussion, both comparative analysis and theoretical sampling have been considered primarily within the scope of an individual study. These techniques are also employed in a larger sense, at a higher level of abstraction. Theoretical sampling can lead from one study area into another area for which the grounded theory has relevance. Comparative analysis can then be made between data from the two areas of study (Glaser & Strauss 1971:178). This matter will be further explored in the following section, which looks at the nature of the grounded theory that is generated with Glaser and Strauss's strategy.

The Type of Theory Generated

According to Glaser and Strauss (1967:32), comparative analysis can be used to generate either substantive or formal theory, both of which they consider to be "middle-range" (Glaser & Strauss 1971:178). They provide descriptions of what they mean by substantive and formal theory:

By *substantive theory* we mean that theory developed for a substantive or empirical area of sociological inquiry — such as patient care, race relations, professional education, geriatric life styles, delinquency, or financial organizations. By *formal theory* we mean that theory developed for a formal or conceptual area of sociological inquiry — such as status passage, stigma, deviant behavior, socialization, status congruency, authority and power, reward systems, organizations or organizational careers. (Glaser & Strauss 1971:177-178)

The two descriptions are quite clear, but the examples offered are a bit confusing. In particular, it is not altogether clear how "delinquency" is more substantive than "deviant behavior". Glaser and Strauss go on to offer an explanation of what they mean by referring to both these types of theory as middle-range:

They fall between the 'minor working hypotheses' of everyday life and the 'all-inclusive' grand theories. (Glaser & Strauss 1971:178)

It is perhaps slightly more difficult to discern exactly what is meant in this second explanation. It is not clear why it would not be possible for some grounded substantive theory, especially in early stages of development, to act as minor working hypotheses. Nor is it clear why it would not be possible for grounded formal theory, if widely and deeply enough developed, to reach the stage of grand theory. In a practical sense, however, grounded theorists are generally looking for something larger than a minor working hypothesis, and would probably be hard put to cover the scope necessary to develop a grand theory. (Atwood [1977] does not even allow that anything but substantive theory can be generated by Glaser and Strauss's approach.)

The generation of substantive theory must precede the generation of formal theory, in Glaser and Strauss's scheme, since deduction from ungrounded theory (assumption and speculation) is not acceptable, and since a formal theory must rest on evidence from a range of substantive areas (Strauss & Corbin 1990:174-175). Thus the generation of substantive theory is basic to all theory generation.

Substantive theory faithful to the empirical situation cannot be formulated, we believe, by merely applying a formal theory to the substantive area. First a substantive theory must be formulated, in order to see which of diverse formal theories are applicable to help further the substantive formulation. And in its turn then substantive theory helps in formulating and reformulating formal theory. Thus substantive theory becomes a strategic link in the formulation and development of formal theory based on data. (Glaser & Strauss 1970)

The basic principles that underlie comparative analysis and theoretical sampling are relevant to the generation of both types of theory, though the strategies vary.

In the beginning, the grounded theorist obtains data in one substantive area. As theoretical sampling proceeds, he gathers data more broadly in the same substantive area, analysing comparatively as he goes along. Thus a substantive theory is developed. It need not remain narrow in scope. "The scope of substantive theory can be carefully increased and controlled by (...) conscious choices of groups," that is, guided by the dictates of theoretical relevance (Glaser & Strauss 1967:52). The fact that a substantive theory is grounded in one particular area does not mean it could not have implications at a more generalized level. Such a theory can become a stepping stone to the development of grounded formal theory (Glaser & Strauss 1967:79).

In the generation of formal theory, comparative analysis is done "among different kinds of substantive cases and their theories, which fall within the formal area, without relating to any one particular area" (Glaser & Strauss 1971:178). Glaser and Strauss acknowledge another way of generating formal theory from substantive theory. That is by omitting substantive words, or writing "up a notch" in level of abstraction. This, they say, is easy, but not very powerful (Glaser & Strauss 1971:179).

Just as theoretical relevance guides sampling within a substantive area, so it also guides the selection of comparison groups in the generation of formal theory from substantive theory. Comparative analysis is then carried out between groups, as it was between individuals in the substantive case. Dissimilar groups will need to be studied. These groups may not be comparable on a substantive level, but must be comparable on a conceptual level (Glaser & Strauss 1971:185-186).

Once grounded formal theory has been developed, it has a variety of uses, according to Glaser and Strauss. These uses include:

guiding substantive research; opening up areas of thought, research, and scholarship; verifying segments of it; modifying and extending it and integrating it with other theory to increase its scope with parsimony. (Glaser & Strauss 1971:194)

They also suggest that it can be

generalized to basic social processes that underlie the issues and problems of diverse substantive areas — for which there is yet no grounded theory. (Glaser & Strauss 1971:194)

Relevant to this, Turner has stated that

The more it becomes possible to predict behaviour in fields remote from those in which the initial data were gathered, selected on the grounds that they take certain of the variables to extremes, the more confidence will it be possible to place in the theory. (1981:242)

As might be expected, most reported research using Glaser and Strauss's approach has involved grounded substantive theory. Many of these researchers make suggestions for extending the investigation into a wider range of similar situations within the same substantive area, and a few recommend exploring other substantive areas in order to identify the possibility of developing formal theory. Fewer yet actually move into the generation of formal theory.

In a study reported in 1978, Wilson and Levy investigated attrition among registered nurses who were students in a degree course. This study was undertaken at California State College, Sonoma, and the resulting theory was used to describe and explain a problem that existed locally, in a defined substantive area.

Melia (1981a:359) explored student nurses' accounts of their work and training. In the end, she found that the study had not arrived at a stable substantive theory, but rather at descriptive and explanatory theory in the substantive area of the student nurses' perspective. It was also viewed within the larger realm of socialization.

Luker (1984) reported on a study of the feelings of undergraduate student nurses about their experiences of "being different" from students in traditional nursing courses. Again, the study produced theoretical material that related to the substantive

area under study, but also related this to a more general phenomenon, in this case “deviance”.

The above three examples, all relating to the substantive area of nursing students’ experiences and perceptions, should not be viewed theoretically only as studies which generated theory grounded in fairly limited empirical areas. Each of the researchers related elements of her discovered theory to relevant existing theory discovered by other researchers. In addition, the work of all three is available for use by further researchers to whose work it is relevant. Thus the three pieces of work are enmeshed in the process of the increasing scope of areas of substantive theory and have the potential to share in the generation of formal theory.

Other examples can be enumerated of the generation of grounded substantive theory in a variety of settings. These include:

- 1) Weiner’s study of pain assessment in an orthopaedic ward (1975), which she related to the organizational features of the ward;
- 2) Atwood’s study of perimortality care (1977), which she recommended should be extended to more varied populations;
- 3) Wilson’s study of the social control of outsiders in a healing (psychiatric) community (1977), from which substantive area she generated an analytic scheme of “limiting intrusion” which she then suggested would be appropriate for developing a “broad-ranging formal theory”;
- 4) Antle May’s study of the experience of first-time expectant fathers (1980), from which she generated a substantive grounded theory describing a typology of detachment/involvement styles adopted during pregnancy by such men; and
- 5) Shover’s study exploring “the later stages of the criminal careers of a group of ordinary property offenders” (1983), the substantive theory generated from which was then compared with other potentially related theories, such as those of Kuhlen (1968), Neugarten (1968), Irwin (1970), Meisenhelder (1977), and Daniel Glaser (1980).

Three additional examples which particularly illustrate the potential for moving into formal theory generation are now offered.

From her study of stepfather families, Stern generated a theory of integrative discipline. She suggested that her theory had “generability [*sic*] to other situations involving integration, management, and discipline.” Comparable situations in other substantive areas could be found, she suggested, in cases where “any new manager (was) attempting to take over in an ongoing system” (1978:55) Thus she was suggesting that the theory generated in a particular substantive area could be worthy of elevation to a higher level of abstraction as formal theory if it could be discovered to be relevant to other substantive areas.

Strong studied interactions among staff, parents and children in children's clinics, and generated several components of substantive theory. Although his data are solely from the children's clinics, he looks beyond substantive theory towards formal theory, such as when he states that "there are quite good grounds for suggesting that the bureaucratic format, or something like it, is a far more widespread phenomenon." He argues that "this format, with one or two alterations, is likely to be the predominant type of ceremonial order in medical consultations within the National Health Service," and suggests that it would be common elsewhere as well, in similar situations (1979: 194).

One would be remiss not to mention Glaser and Strauss's own work in this context. Moving on from their early studies of dying (Glaser 1966a, 1966b; Glaser & Strauss 1964a, 1964b, 1965a, 1965b, 1966), they drew on their own subsequent work, the work of colleagues, and the work of others in different but analogous substantive areas, and generated their formal theory related to "status passage" (Glaser & Strauss 1971).

The Use of Interviewing in Qualitative Research

The most frequently used methods of data collection in qualitative research are usually said to be participant observation and interviewing (Becker & Geer 1957 & 1958, McCall & Simmons 1969, Levanthall & Israel 1975, Melia 1982, Polit & Hungler 1985, Chenitz & Swanson 1986). May (1991:188) claims that interviewing is the single predominant mode, though some researchers (e.g. Denzin 1978, Melia 1982) have suggested that there is no clear-cut distinction between interviewing and participant observation, since qualitative interviewing involves the interviewer closely in the production of data. In many cases, a combination of the two methods is appropriate, particularly when information about behaviour and about individual attitudes and perceptions is sought.

In the present study, interviewing was the method of choice, as there was no behaviour to be relevantly observed. Neither the students' behaviour nor the behaviour of others during their nursing experience was relevant to the study, except as the students might give accounts of them. The topic under investigation related solely to the subjective perceptions of student nurses, and there was no concern for the truth of their accounts, except in the sense of how true they were to the students' own mental pictures. Interviewing offered the best route to such data.

Maccoby and Maccoby (1954:450) have defined the interview as "a face to face verbal interchange in which one person, the interviewer, attempts to elicit information or expressions of opinions or belief from another person or persons." McCracken

suggests that the long interview “gives us the opportunity to step into the mind of another person, to see and experience the world as they do themselves” (1988:9). Both these views suit the needs of the present study.

Interviews have been categorized in a variety of ways — formal or informal, structured or unstructured, respondent or informant, single or repeated, individual or group. Researchers are not all in agreement as to the definitions of all these dimensions. Antle May (1991:189) suggests that “interview procedures used in a given study cannot be accurately described until after the fact,” implying that the description of an interview style needs to be individualized rather than categorized according to set parameters. However, a consideration of the issues involved is useful at this point.

According to Chenitz (1986), the difference between the formal interview and the informal interview has to do with whether, on the one hand, it is arranged or, on the other hand, it occurs in the natural setting without pre-arrangement. If an interview is artificially arranged as to time and place, Chenitz would classify it as formal. Antle May (1991) implies the same distinction. However, many researchers indicate that the difference between formal and informal interviews has more to do with the style in which they are conducted. That is, an informal interview can be pre-arranged, but the style of the interview is non-directive on the part of the interviewer (Cohen & Manion 1985). Certainly, an interview that is both pre-arranged and controlled by the researcher is a formal interview. In general, the less formal style of interview would be characteristic of qualitative research, since it would have the characteristic of being less controlled and would therefore be appropriate when theory was being sought rather than tested.

The distinction between structured and unstructured interviews is, on the face of it, less problematic. A structured interview is conducted according to a pre-determined plan, and the same set of information is sought from each interviewee. At the other end of the spectrum is the unstructured interview which has no advance plan, and in which the information gleaned is totally dependent on what the interviewee chooses to bring into the conversation.

Denzin (1978) suggests three types of interviews, according to degree of structure: the schedule standardized interview, in which questions are all strictly planned as to wording and order; the nonschedule standardized interview, in which a predetermined set of information is sought, but the wording and order of questions are not strictly planned; and the nonstandardized interview, in which nothing is prespecified.

Once again, the style of interview implying the least control is generally considered to be more appropriate to qualitative research. Curiously, though, McCracken (1988: 24-25), in a series on qualitative research methods, insists that a fixed questionnaire is indispensable to any interview. It should ensure, he says, that “the investigator covers

all the terrain in the same order for each respondent," and he states that "prompts must be carefully crafted, and precisely situated, in the interview." He further says that the questionnaire "protects the larger structure and objectives of the interview." He believes that such structuring does not handicap the "elements of freedom and variability within the interview," but his argument is not very convincing. His view takes insufficient account of the natural conversational flow that is often desired in qualitative interviewing. In particular, his recommended approach must be alien to the aims of grounded theory research, as subsequent interviews need to be tailored to the requirements of theoretical sampling and the need to try and saturate categories that arise from data from earlier interviews, and therefore cannot all be identical as to the questions asked and the order of their asking.

Antle May's advice on structure seems more realistic. She indicates that qualitative investigators "begin with largely unstructured interviews, exerting only as much topic guidance as is necessary in the interview to elicit the informant's story." Clearly, she does not envisage precisely worded questions, and gives the reason for this.

Since the salient parameters of the topic cannot be identified until several informants' stories are heard and analysis begins, active topic guidance or control early in the investigation is counterproductive. (1991:191-2)

She goes on to describe the appropriate modification as a study proceeds.

... interviews often become more focused as the investigator uses more topic guidance to explore areas of special interest, begins to test preliminary findings, or begins to look for areas of commonality and difference in respondents' stories. (1991:192)

Thus she indicates that whether the interviews are unstructured or semi-structured/focused has to do with when in the process they take place.

A curious feature of both McCracken's (1988) and Antle May's accounts is the apparently interchangeable use of the terms "respondent" and "informant". Other researchers make a clear distinction between these terms. Powney and Watts (1987), for example, classify interviews as respondent interviews or informant interviews depending on the degree of control the interviewer exerts over the procedure. In a respondent interview, the interviewee responds to the set questions the interviewer asks. In an informant interview, the interviewee expresses "his or her own concerns and interests without feeling unduly hampered" (1987:18). Further to this, Powney and Watts cite from a symposium paper presented by McDonald and Sanger the notion of "tactical opportunism". This is employed when the researcher is unsure what information will be available from the interviewees and uses unstructured informant interviews as a form of reconnaissance. This seems to be very much in line with the tenets of grounded theory.

The choice of single or repeated interviews depends on the purpose of the research. As Antle May suggests:

one-time interviews may be best when access to informants is difficult or when the topic area can be covered readily on one contact and does not require substantial rapport and trust for exploration. Repeated contacts may be needed when change over time is of interest or when the interest area is best understood from a position of more familiarity and closer rapport with the informant. (1991:189-190)

Similarly, the decision of whether to interview subjects individually or in groups, and what sort of groups, depends on the purpose of the research and how data about the phenomena under investigation are most likely to be elicited.

In the present case, the choice was made to use informal interviews, with regard to their style of conduct, but formal in the sense that they were pre-arranged. It was important for the purpose of the study to hold them at appropriate points in the students' training, and it was unnecessary for them to occur naturally. Interviews were largely unstructured to begin with, with only a loose agenda of topics to be covered, and no exactly prespecified questions, until theory began to be generated from the data, at which time the agenda became more complex. They would be best defined as informant interviews, as the aim was to elicit the students' own perceptions rather than their responses to specific questions based on a set theoretical structure. They were repeated in order to identify the nature of the development of the students' ideas and perceptions, and they were conducted with individual students as it was the ideas of students as individuals that were being explored.

Chapter 4

STUDY DESIGN AND DATA ANALYSIS

This chapter explains the design of the study that was carried out. It describes the selection of students for interview, the process of the data collection, including details of method and timing, and the manner in which data were analysed, using the technique of comparative analysis.

The Interviewees

The subjects of interest were student nurses who were just starting their professional training.¹ The intention was to begin by obtaining data from students whose images were not yet contaminated by exposure to the views of staff or other students, or to experiences within the training programme.

There was no reason to suppose that students from any institution would be more appropriate than students from any other, as long as the researcher was not a member of the staff involved in their teaching. Therefore the initial sample was selected from a single Scottish nursing college that was reasonably accessible. This college will be referred to as "Scotsburgh College of Nursing". The first-level programmes at this college were modular in design, following the curriculum of the Scottish 1982 Scheme. They included training for the register in all the four nursing fields: general (adult) nursing, mental (psychiatric) nursing, mental handicap nursing, and sick children's (pædiatric) nursing. Each student selected her field of nursing at application and entered for the relevant programme.²

Permission for access was first obtained from the Director of Nurse Education at the College, and the cooperation of the senior staff responsible for student intakes was then sought. To achieve this, the researcher attended a senior staff meeting and presented an outline of the planned study. This was done without giving too much detail about the type of data to be pursued, as it was feared that otherwise teaching staff might inadvertently give information to students that might prejudice the nature of their responses. The relevant senior managers gave their agreement in principle to the researcher's use of a short period of class time during students' first week in training, and the researcher was to contact each senior manager individually as and when contact with an intake group was desired. The cooperation of students was enlisted in

¹ Throughout this paper, the term "training" will be used to indicate a training/educational programme in basic nursing. This is not intended to have any particular educational implications, but is merely a matter of convenience, and fits with common usage.

² Student nurses will be referred to as "she" except when a specific male student is being referred to. "She" should therefore be taken to indicate "she or he".



meetings with the groups involved, and via a questionnaire and sign-up sheets, as indicated below.

The first individuals for interview were selected purposively from one intake of first-level student nurses at the college. Their programme began with a four-week Introductory Course (I/C) common to students in all four types of training. This was followed by their first clinical modules. The first week of the first module was spent in college. This meant that the students were available pre-clinically for a period of five weeks.

Out of a total of 54 students in the group, 40 indicated a willingness to participate in an individual interview (see next section). Not all of these could be interviewed in the time available prior to their first clinical experience, and in any case, that large a number was not necessary to the requirements of the study. A preliminary selection was made of 20 of those who had indicated their willingness. This selection included a diverse group of students, based on the variables identified on a biographical questionnaire (see Appendix 1), so that no single type of student was over-represented. It included females and males, students with and without previous work experience, with and without relatives in nursing, with varied levels of academic qualification, of varied ages, from varied geographical areas, and representing all four types of training. A timetable was posted in their classroom offering several interview times during the second and third weeks of their I/C, and asking students from the selected list to sign up for a time at which they were available and willing to be interviewed. Thus the initial interviewees were students who had first indicated on the questionnaire that they were willing to be interviewed, were then selected as fitting the purpose of the research, and finally specifically volunteered by signing up for an interview time.

In this way, three interviews were conducted during the second week of the students' I/C and four during the third week. A subsequent selection from the group of willing students was made, including some of the students from the initial list but omitting others and adding some new names, again to avoid over-representation of types. In addition, the selection was now also based on ideas developing from the data from the first interviews. This process was carried on throughout the first five weeks of the group's nursing programme, and in all twelve students from this intake group were interviewed. As it turned out, there were no males among the twelve, nor were there any students training for mental nursing. This was unintentional, the result of the voluntary nature of the signing up procedure.

It was initially thought that a total of twelve students might be sufficient for interviewing, with some or all of them being interviewed on one or two further occasions later in their training. However, early analysis of the data indicated a need to gather more data from beginning students. For example, it became apparent that one of the

themes being pursued would be better served if it could also be explored with students training in mental nursing. It was therefore decided to select an additional sample from the next intake group, which entered three months after the first group.

A similar procedure was followed in selecting the interviewees from the second intake group, except that now subjects of specific types were sought to a greater extent than in the first group, in the process of theoretical sampling. Out of a total of 50 students in this group, 26 were willing to be interviewed. The timing of this intake was awkward for the researcher, due to work responsibilities, and it was only possible to carry out a further five interviews with this group. Therefore, additional students were selected from the intake group that entered three months later, that is, six months after the first group entered. This third group included 58 students, of which 45 were willing to participate, and seven of these were interviewed.

It should perhaps be mentioned at this point that although it was emphasized at the researcher's initial meeting with each group that completion of the questionnaire was entirely voluntary, and that no report would be given to their tutors or to anyone else at the college as to which or how many of them had filled out the questionnaires, there was 100% return in all three groups (a total of 162 students).

In all, then, 24 students chosen from three successive intake groups at Scotsburgh College were interviewed before the commencement of their clinical experience as student nurses. The distribution of students according to intake, sex, and type of training can be seen in Figure 4.1.

The interview group was compared with the total group from which it was drawn, using SPSS-X on a Honeywell Bull CP-6 system, after the data collection was complete. This was done not to establish any basis for generalization, but merely to see how representative the sample might be of the population from which it was taken.

The 24 students interviewed constituted 14.8% of the total group of 162 in the three intakes. In the total group, eleven (6.8%) were male. Of the interviewees, three (12.5%) were male. The interviewees included a smaller proportion of students undertaking adult general nurse training (54.2%) compared with the overall group (71.6%). The proportion of students in the whole group undertaking sick children's training (12.3%) was similar to that in the interview group (12.5%), whereas mental handicap nurse training was over-represented, at 20.8% in the interview group compared with 7.4% in the total group, as was mental nurse training, at 12.5% compared with 8.6%. These differences ($P < 0.075$), did not imply a problem, as the numbers used were specifically desired for the purposes of theoretical sampling.

Geographically the interviewees were broadly similar to the whole group. By birth, 91.7% were Scottish, with 84.6% of the total group being Scottish, and 25%

Figure 4.1

Numbers of student subjects
(Total = 24)

<u>INTAKE</u> <u>GROUP</u>	<u>RGN</u>		<u>RMN</u>		<u>RNMH</u>		<u>RSCN</u>		<u>Totals</u>	
	<u>F</u>	<u>M</u>	<u>F</u>	<u>M</u>	<u>F</u>	<u>M</u>	<u>F</u>	<u>M</u>	<u>F</u>	<u>M</u>
<u>Jan 1987</u>	7				3		2		12	
<u>Apr 1987</u>	2		2				1		5	
<u>Jul 1987</u>	3	1		1	1	1			4	3
<u>Totals</u>	12	1	2	1	4	1	3		21	3

resided locally as compared with 24.7% of the overall group. Neither of these differences was statistically significant.

On the measure of previous work experience, the interview group differed from the total group, with 100% having had such experience, but only 81.5% of the total group having worked before they commenced their training ($P < 0.025$). As regards work related to nursing, 33.3% of the interviewees had had previous experience, whereas 56.8% of the total group had had such experience ($P < 0.053$).

The interview group was, on average, slightly older than the whole group, with a mean age of 20.9 years compared with 19.6 years. This difference ($P < 0.111$), was accounted for by the fact that the interviewees were selected to represent a spread of ages, whereas the total group had a larger proportion of students aged 17 to 18 years.

With regard to school qualifications, the interviewees were fairly similar to the whole group. Their mean number of "O-grades" was 7.4 and in the total group it was 7.2, while the mean number of "higher-grades" was 2.75 in the interview group and 2.4 in the total group. These differences were not statistically significant.

Finally, the interviewees had a greater mean number of relatives in nursing, 1.79 compared with 1.38 in the total group ($P < 0.158$).

The computations of statistical significance in this study are, of course, of limited value, given the small size of the interview group.

The Data Collection

The main method of data collection in this study was to be the informal interview. However, a potential problem was foreseen. The aim of the interviews was to elicit the students' perceptions of their image of nursing at the time they entered training. It was going to be impossible to conduct all interviews at the exact point of entry. This meant there might be changes in students' images brought about by their early days in training, by the time of interview.

This possibility was compounded by the researcher's circumstances, in combination with the I/C timetable. I was working full-time at a busy teaching job, which meant that there was a limit on the amount of time I could spend, as well as on when that time would be available. The I/C timetable had no more than one class period per day that was not allocated to formal teaching. Such periods were designated for "study", but students were free to use them at their discretion as long as they remained on the college site.

It seemed unwise to expect students to give up their tea or lunch breaks, especially as they were establishing social relationships with classmates and break times provided an opportunity for this. I decided not to ask them to use their personal time, apart from the time just after the last class of the day. In part, this was for logistical reasons, as they lived in a variety of places. In addition, I did not want to impose on their generosity unnecessarily, as I anticipated that I would wish to interview them again.

Thus the only time available most days was during a designated study period or after the last class period of the day. This meant that some interviews would take place late in the I/C, or even during the first (college) week of the first module.

I therefore decided to administer a small questionnaire at my initial meeting with the students. I had in any case intended to ask them to answer a short set of biographical questions, to assist me in selecting individuals for interview. To this were added three open-ended questions to tap their ideas about nursing. (See appendix 2.) It was never intended to analyze fully the data obtained from these questions. Rather, they were meant to provide a reference point for initial interviews if needed. For example, if a student at interview offered ideas that differed from those expressed in the questionnaire, the differences could be explored during the interview.

ADMINISTRATION OF QUESTIONNAIRES

Questionnaires were administered to three intakes of student nurses, as described in the previous section. These intake groups will be referred to as A, B and C. I was given access to the A and C groups first thing on their first day in training, and to the B group on the Wednesday morning of their first week. The timing of the meeting with this

middle group was not ideal, because there was the danger that they had already begun to modify their ideas, but the senior tutor responsible for that group did not wish the researcher to have access to "her" students before she had established a relationship with them herself.

As has been mentioned, there was 100% return of questionnaires from all three groups. A final question on the questionnaire asked whether the respondent would be willing to participate in an interview. It was indicated that a "yes" answer at this point was not binding. The rate of positive response to this question has been covered above.

CONDUCT OF THE INTERVIEWS

The first-round interviews all took place before the students began working in clinical areas and were conducted in a neutral room (a vacant tutor's office) within the nursing college. Second interviews were carried out with all the students, and these took place during the students' second modules.

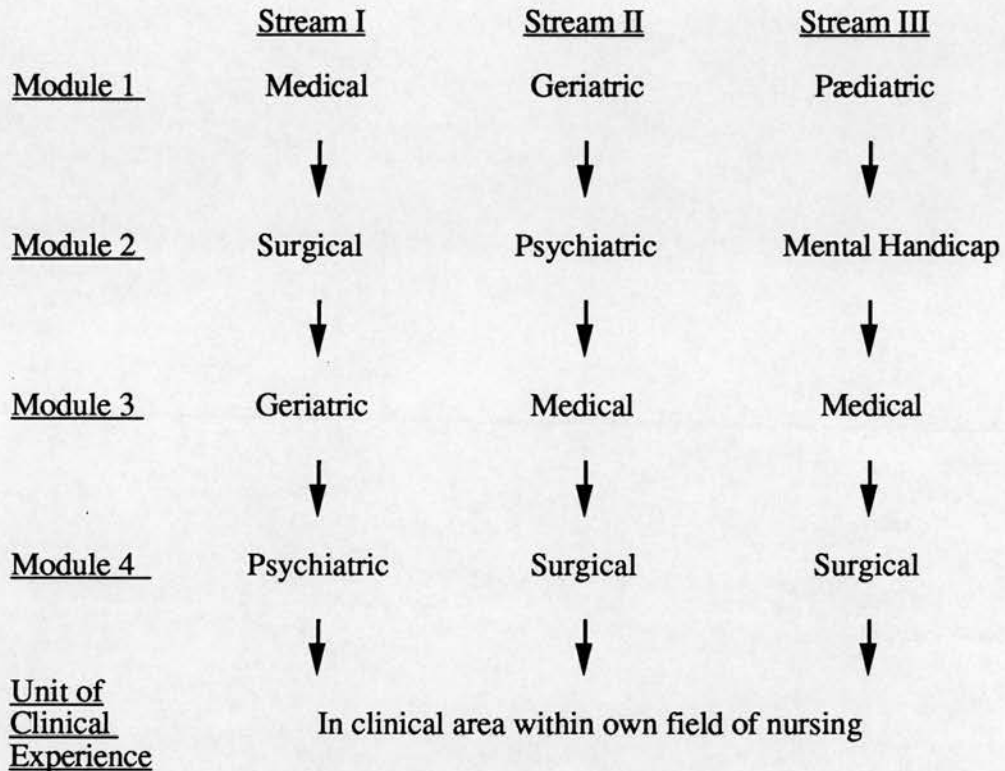
Because the students were in three different "streams", their clinical experiences were varied at the time of their second interviews. Some were interviewed during a surgical module, having already completed a medical module; others were interviewed during a psychiatric module, having completed a geriatric module; the remainder were interviewed during a mental handicap module, having completed a pædiatric module. Thus among the three streams there were no clinical experiences in common at that point. (See Figure 4.2.) Partly for this reason, but also because of the direction and extent of movement being identified in the conceptual themes arising from the data, it was decided to carry out a third set of interviews with the same students. These took place during the students' fourth module or during the "unit of clinical experience" which followed it. By that time, all students had in common that they had had experience in medical and surgical nursing.

Most second and third interviews were conducted in a quiet, private room in or near the student's clinical area. Permission for each of these was obtained from the relevant nursing manager, after the student had agreed to participate in the additional interview. If such a room was not available, or if a student felt more comfortable being away from the clinical area, a neutral office in the nursing college was used.

All interviews were recorded on audio cassettes. Students were asked if they objected, before each interview. No student objected, and the presence of the recorder did not appear to inhibit conversation. Interviews were transcribed verbatim, apart from sections that were clearly chat rather than interview. Transcriptions of students'

Figure 4.2

Plan of first stage of training



previous interviews were taken along to second and third interviews, and students were offered the opportunity to look at them if they wanted to. The length of interviews varied from 25 to 60 minutes, with most being 40 to 45 minutes. In general, later interviews were longer than the earlier ones.

In the intake system operating at Scotsburgh College, the second module of one intake took place before the group of students entering two intakes later had started its first clinical placement. (See Figure 4.3.) Therefore, some students from the A group were interviewed for a second time before some students from the C group were interviewed for their first time. This turned out to be a useful feature of the timetable in relation to theoretical sampling, because it provided ideas which helped to guide the selection of students to be interviewed from the C intake, and it suggested theoretical themes that were introduced into the content of the later first interviews. Early interviews with the A group had the loosest of structures, and their direction was largely dependent upon what the students chose to bring into the conversation. Initial

Figure 4.3

Sequence of entry groups
(first year of data collection)

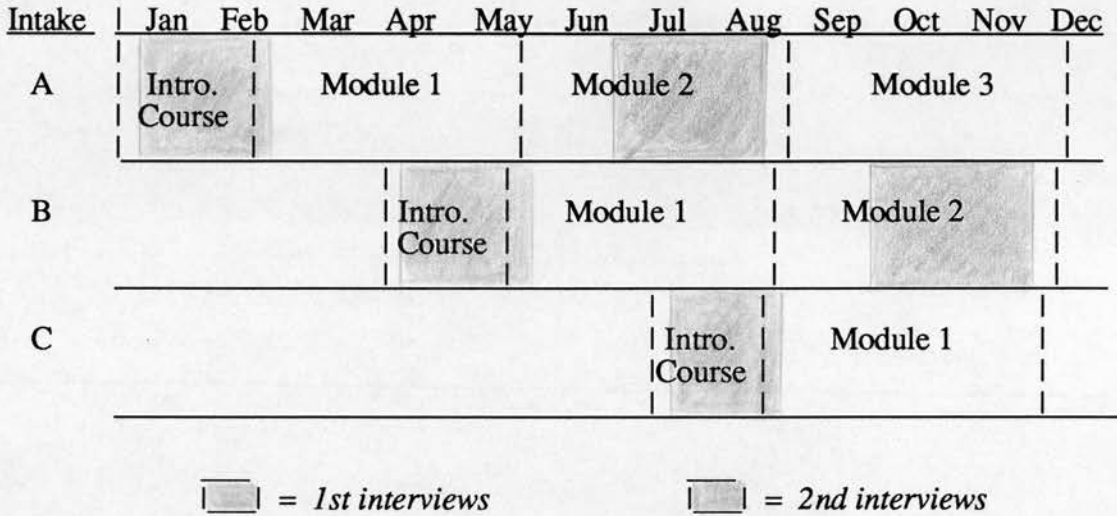
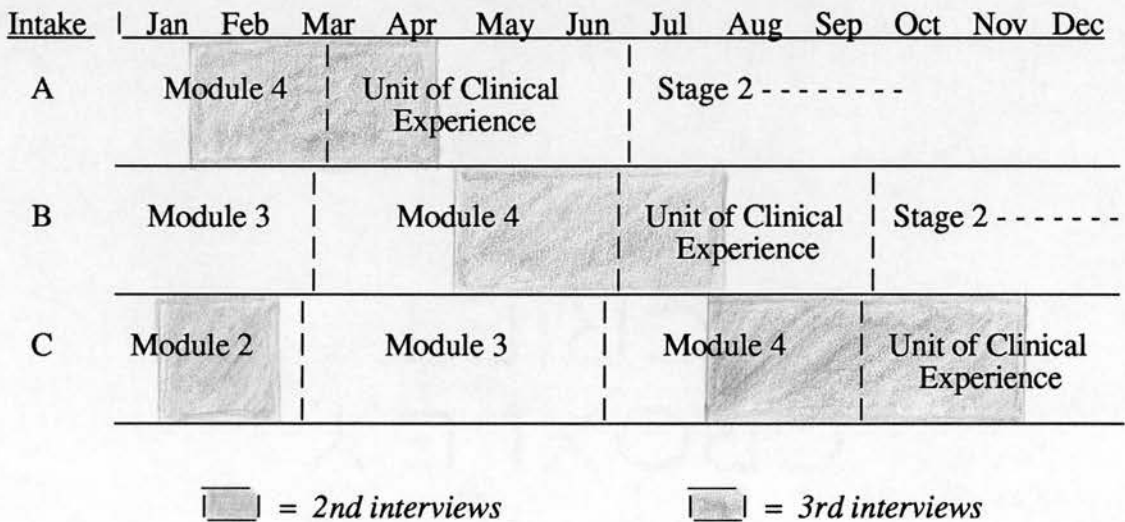


Figure 4.4

Sequence of entry groups
(second year of data collection)



interviews with students from the C group, while including whatever elements the students brought up, also included elements brought in by the interviewer, arising from ideas that emerged from second interviews with the A group as well as previous first interviews with all three groups.

A similar pattern occurred with the timing of second and third interviews. (See Figure 4.4.) Although at this stage the overlap had a similar influence on the content of the interviews, it did not have any effect on the selection of students for interview, since the study was not designed to include any students other than those who had had an initial interview before their first student clinical experience.

In the first interview in the first set of interviews, a few topics made up a rudimentary interview schedule, and the direction of the interview itself was largely determined by the nature and direction of the student's responses. Subsequent interviews gradually took on a more defined agenda as themes began to appear from data thus far obtained, though the order in which the themes were discussed varied considerably.

A specific example will illustrate this. The initial intention, as regards the interview schedule, was to attempt to discover what came to the student's mind when she thought of nursing. This began with the simple question:

AK – How do you see nursing?

Her answer was:

St – I suppose mainly I see it as caring.

When encouraged to elaborate on what she meant by caring, she indicated that it involved both physical and emotional elements. She then enlarged on the physical aspects by listing tasks that she imagined nursing involved:

St – ... taking TPRs, giving injections, if they're incapable washing them, making sure they're clean and tidy.

In subsequent interviews, this idea of what tasks were involved in nursing work was pursued. Sometimes it came up quite naturally in line with an idea the student was discussing spontaneously, but if it did not come up spontaneously, I brought it into the discussion.

One point needs explanation here. Elements that I introduced into the discussion were followed up if they seemed to strike home with the student, but were abandoned if they appeared to have no meaning for her. This seemed to be essential to the study, since it was the students' own images of nursing which were being sought, not images they were forced to consider. Again this is probably best clarified with examples.

When asked about what they thought nursing was, some students offered occupational labels for it, such as "profession", "career", "vocation", and so on. In

later first interviews, a student might be asked the same question and not have anything to offer. I might then ask about some of the specific terms that had been offered by other students. One student, when offered "calling", said:

St – Yeah, that's a good one.

I then pursued this idea in order to find out what that meant to the student, since it obviously did have meaning for her. Another student, however, in similar circumstances, said:

St – Mm-hmm. Well, I don't know. What do you mean by calling?

At this point I decided to go a bit further, not quite sure whether the word meant anything to the student or not, and not wanting to define it for her.

AK – It's just a word, I offered it without a meaning, if you said yes, I would say "What does that mean to you?" [both laugh]

St – Yeah, probably ... I don't know. It's something, I think you've probably to to have it in you to do it.

I thus did not force the student to use the word which did not in fact seem to be a word she would use. However, I was able to find out something about her image of what sort of occupation nursing was.

One tactic that proved to be effective in eliciting information about the students' nursing images was to ask them to imagine a picture of a typical nursing scene and tell me what was in it. Some students responded by describing a ward scene. I could then ask them about details that were in the scene. Others began by describing a nurse at a bedside. I could get them to put this in context by asking them if they could see the setting in which it took place. Either way, I could usually get both a picture of the scene or setting, and a picture of the actors in the setting, particularly the nurses. One student provided a particularly spontaneous set of responses to this:

AK – And what does the nurse look like?

St – She looks a bit strict, you know, she's a bit austere.

AK – Uh-huh. And how can you tell that, when you look at her?

St – Just her face, she's not smilin'. [laughs] A weird picture!

AK – Is she a qualified nurse, or is she a student, or what?

St – Yes, she's already qualified. She's oldish, as well.

AK – Oldish, uh-huh. And how is she dressed?

St – Maybe blue, with a white cap.

AK – (...) are any of the patients smiling?

St – No. ... They're not very happy.

AK – So it's not a very happy ward, this?

St – It's weird!

AK – Is this, do you know where this ward came from? Is it anyplace you've worked, or seen?

St – No, no. It's not what I think, not at all!

AK – It's just the picture that comes into your mind?

St – Yeah.

It seemed as if this student was actually finding an image in her mind that she hadn't known was there until she looked, but it *was* there. Interestingly, she had worked in two wards during a pre-nursing course, both of which were happy wards and bore no resemblance to the ward of her mental image. This seemed to be a genuinely spontaneous description of that mental image, and the data gleaned from it were therefore useful to the study.

A final point to be made here relates to the further pursuit of themes from first interviews during second and third interviews. Sometimes a theme seemed to be emerging from data from later first-round interviews that had not been recognized in earlier ones. In some cases, there was actually relevant material within the earlier interview data, so it was possible to work back through those data and identify it. In other cases, there was nothing relevant to be found, because the discussion had not covered that ground. In such cases, a note was made to bring the theme into the next interview with that student.

An example of this is the idea of police work. The first two students interviewed both mentioned police work. At this time, the topic was not pursued, because it had not been the intention of the study to explore alternative occupational fields considered by the students. The topic was not mentioned again for three or four interviews, but it then began to appear with some regularity, in interviews with both male and female students. I gradually began to discover that pursuing a discussion of police work was uncovering a new slant on students' images of nursing. It was possible then to go back to the early interviews and see if any of the data there helped to fill out the picture I was getting. Sometimes, however, the data were incomplete in that regard, and of course, sometimes the idea of police work had not been mentioned at all. I then planned to bring it up in the next interview with a student if it had not been covered, or not covered adequately, in the first interview.

A COMMENT ON THE RESEARCHER'S ROLE

Before commencing the data collection, I was conscious of the need to maintain my identity as researcher. I anticipated possible situations in which I would feel tempted to act as teacher or guidance counsellor to the students I was interviewing. I also anticipated the possibility of recognizing, during the course of an interview, a student's need for help or counselling, and I planned for the action I would take in such a case.

As it turned out, this was rarely a problem. Most occasions that stimulated tutor or counsellor feelings were minor, so it was easy to bite my tongue and not slip into a non-researcher relationship with the interviewees. On the single occasion when it became impossible to maintain the role of researcher, the student indicated that she had come to me for advice about a problem, and not to be interviewed. In confidence on both our parts, I directed her to the right type of help, and no research relationship was established between us.

An unanticipated concern did arise, however. I had realized when planning the data collection that I might alter my student subjects in some way by asking them to think about things they might otherwise not have given conscious attention to. For this reason, I knew they might be changed in some way by participating in the study. What I had not foreseen was that I might serve a function for the students.

I noticed in the second-round interviews that students tended to thank me at the end of their interviews, adding comments such as, "I'm glad you came today." One in particular stood out. She looked stooped and glum as she came into the room for her second interview, unlike at her first interview, when she had appeared bright and bouncy. Despite her apparent low spirits, she was friendly and cooperative throughout the interview, and remained expressive and spontaneous, and we talked for 50 minutes. When she stood up to go, her shoulders were straight, there was a bounce in her walk, and she said, "I'm really glad you came this morning. I feel much better now. I think I needed to talk about all those things."

During second and third interviews, I wondered how concerned I should be about this. It seemed I had to assume the interviewees may have become less representative of their student groups as a result of the interviews. I considered interviewing additional students during later modules only, students I had not interviewed during their I/C and who would thus be uncontaminated by me, to fill out the data related to the progression of the conceptual themes I was identifying. However, I rejected this idea, as the movement of themes that was being explored emerged from within data from each student, rather than being generalized across the group. For any new students, there would have been no initial data with which to compare the later data and hence no way to identify such movement.

The phenomenon is nevertheless meaningful. This function which I inadvertently served for these students was an important one, often not catered for in any other way, in their view, as became apparent during data analysis. It is not difficult to speculate as to why I was able to serve this function, totally serendipitously, despite the fact that in the interviews I made no attempt to advise, counsel, or guide the students' thinking. I suspect that it is explainable by the fact that I was "nobody" to them. I was not one of their teachers, not a member of the ward staff, not a parent, not a friend, etc, and I did not report anything to any of these people. The students knew that they were speaking to me in confidence, and that anything they told me would only ever be recounted anonymously. One student expressed this, indirectly. She told me in her second interview that she was planning to quit her training. When I asked if she had told her parents or tutors about it, she said no, that she wasn't going to tell anyone yet. Clearly she did not see me as "anyone".

In addition, my only reason for interviewing the students was that I was interested in what they had to say. This meant that they could say whatever they wished and I would listen, and this seemed to fulfil a need for them. There were indications in what some of the students said about their experiences that they were aware of having needs of this kind that were not being met, so it is perhaps not surprising that when I came to listen to them, the students found this a useful exercise.

There was another apparent effect of my interviews which I was able to specifically identify in one instance. In a third-round interview one student gave an account of changes that had taken place in the clinical area where she had spent her first module. She had been acquainted with a few other students I had interviewed and they had discussed among themselves some of the issues they had told me about in their respective interviews. The clinical area in question had posed a number of problems for them, and they discovered that they had all mentioned this when talking to me. They then decided it would be useful to try to do something about the problems, so they set about making representation to the relevant clinical manager, and a number of the problems had been successfully addressed by the time I was interviewing the student for the third time. It is doubtful whether the students would have thought of taking this particular step had it not been for the stimulus of their interviews with me which prompted them to discuss the problems constructively among themselves rather than just complaining about them *ad lib*.

These sorts of outcomes have to be accepted as potential side effects of qualitative research. As was stated earlier, the students may have become unrepresentative of the larger group, but this is arguably impossible to avoid if one wishes to obtain the type of data required for such a study.

ETHICAL ISSUES

In addition to the issues alluded to in the previous section, there were other ethical concerns implicit in this study.

Transcription of the students' interviews was carried out using a word processor on a personal home computer. In accordance with the requirements of the Data Protection Act, the relevant person at the Health Board in which Scotsburgh College was located was notified of this fact. In addition, students were informed that they had the right to view the data held from their own interviews. As has already been mentioned, they were offered the opportunity to view printouts of previous interviews when I returned for subsequent interviews.

Confidentiality was an important ethical issue, given that the data contained personal information about students as well as patients, clinical staff and teaching staff. Students were assured that all information would be handled anonymously, apart from my own need to keep track of names in order to follow up students for subsequent interviews. This involved my changing the names of the students, any other individuals they mentioned in their interviews, and any hospitals or wards they referred to. There would inevitably be information mentioned or quoted that the students themselves would recognize as their own should they read it, but this would imply no breach of confidentiality since it would be identifiable only to themselves unless they chose to tell anyone else.

One ethical problem that was encountered related to poor practice, as recounted by the students. There were instances of students who were apparently receiving an inadequate standard of support and/or unsatisfactory treatment by service or teaching staff, sometimes to the point of unfairness. These instances were worrying but were only rarely serious in nature, and never appeared to cause real danger. For this reason, it was decided that it would be inappropriate for the researcher to take any action.

ISSUES OF RELIABILITY AND VALIDITY

Issues of reliability and validity were considered in the planning of the study, the conduct of the data collection, and the analysis of the data.

Reliability in the sense of the study's being replicable cannot be claimed, but nor was it expected or sought. Chenitz and Swanson suggest that the appropriate test for reliability in qualitative research "is through the use of the theory and its applicability to similar settings and to other types of problems over time" (1986:13-14). This implies that it will be impossible to comment on the reliability of the results of this study until there has been time for later comparisons to be made, by the same researcher and/or others. It has been possible, however, to assess this to a certain extent by comparing

the discovered theory with that derived from other studies. This would support a contention that an acceptable degree of reliability existed.

Brink suggests a more complex set of criteria for establishing reliability. She names three tests, beginning with:

- 1) stability over time is tested through repeating observations of the same events to look for similar occurrences or by asking informants identical questions of the same content to establish the consistency of the answers. (1991:176)

Application of this test to the present study is awkward. The notion of "events" is not directly relevant to the phenomena being investigated, so it would be the second part of the test that should be applicable. However, it was the point of the study to ask students questions about the same phenomena over time in order to identify how their perceptions *changed*, as it was likely that there would be at least some change resulting from the meeting of their images with nursing as they experienced it. Therefore, lack of consistency in subsequent accounts did not indicate lack of reliability, they were the stuff of which the theory was to be constructed. Stability was not expected.

The second and third of Brink's tests seem to be strongly related to each other:

- 2) internal consistency is judged by the logical or explanatory rationale of ideas about the same topic within a single interview session; and
- 3) equivalence is tested by asking different kinds of questions within the single interview or questionnaire in order to establish the equivalence of the data elicited regardless of the form of question. (1991:176)

To a large extent, the results of these tests were positive in the present study. That is, within individual interviews a logical picture resulted from exploring students' ideas from various angles, and their accounts were largely consistent within themselves. There were cases of inconsistency, such as when a student might say at one point in an interview that nursing was pretty much as she had pictured it, and would later discuss ways it differed from her picture. However, it seemed that these cases related more to the students' own uncertainties, and perhaps to the multiplicity of perceptions present at the same time within their images. It seems reasonable again to conclude that there is an acceptable degree of reliability in this regard, but it was important in conducting the interviews to explore the various facets of the students' accounts in order to identify, confront, and attempt to resolve the inconsistencies.

The selection of subjects is one of the researcher's first concerns in relation to bias and therefore validity. In this study, the "sample" was neither random nor necessarily representative. The first subjects were selected purposively, and later ones according to the direction of emerging theory. All were volunteers. Their selection has been

described in detail elsewhere in this paper, but suffice it to say here that there is no reason to believe they were atypical of the population from which they were taken. There was no intention to generalize or predict from the results of the study, so the validity and reliability requirements that would apply to sampling for a quantitative study did not apply here. As the intention was to understand the perceptions of the students being studied, those students must necessarily be appropriate subjects.

Chenitz makes the following statement:

It is the task of the researcher to unearth the relative truth in the situation, to discover the range in people's beliefs, and the congruence between belief and action. This is the validity for which the qualitative researcher strives. (1986:87)

She goes on to indicate that assurance of validity is only possible if the researcher employs both observation and interview in collecting data. That is, the researcher has to be able to view the event, including the subject's behaviour, and to explore the subject's opinions, feelings and motivations with regard to the event and her/his behaviour. This view assumes that the phenomenon under study entails observable events and/or behaviour. In the present study, the phenomena being investigated only existed in the minds of the subjects, and as they cannot therefore be observed, the only access available was via the subjects' own accounts. Knowing how they behaved in any particular situation would not have contributed any useful data.

Various strategies were employed to minimize bias and increase validity. Careful consideration was given to how the researcher presented herself to the student groups. This was important, as any indication that she represented "the establishment" could have jeopardized the freedom students felt to express themselves honestly. Therefore, at the meetings arranged with each of the three intake groups, the researcher introduced herself without any member of the teaching staff being present, using her first name. She stressed that she was a part-time university student, and dressed casually to reinforce this identity, attempting to avoid a tutor-ish style of personal presentation.

Interviews were conducted in such a way as to avoid superior-to-inferior connotations. All initial interviews were held in a vacant tutor's office, but not from behind a desk, and the interviewer and interviewee sat in similar chairs. Interviews in the second and third rounds varied as to location. Most were held in the clinical area, in an available room such as an interview room, empty patient room, or unused office. Some interviews were held at the college, either because the clinical area did not have an appropriate space to offer or because the student preferred it that way. In all interviews, the researcher dressed neatly but casually.

The success of the interviews in eliciting apparently uninhibited responses from students seemed to indicate that these tactics achieved their aim. For example, students

often gave candid accounts of their views of staff, whether favourable or unfavourable, and it is unlikely they would have done so if they had suspected that the information would be passed on or would be attributed to them.

As is often true with research, particularly with qualitative studies in which the researcher interacts personally with the subjects of the research, there was a risk that the findings of the study were in part influenced by the presence of the researcher herself or by the subjects' participation in the research process. In fact, it seems certain that this did happen, as has been discussed earlier.

There were probably many subtle ways in which students, and potentially the data elicited from them, were affected by the researcher and by the study itself. At the very least, participating in the study may have made students examine perceptions they had not consciously considered before.

It could be contended that such influence led to bias, and thus had implications for validity. This is difficult to deny, and although such effects may be excused on the grounds that they could not be avoided, they must be kept in mind when assessing the theory generated in the study.

In relation to the analysis of data and the theory discovered through its interpretation, a problem exists when a research project is based only on interviews conducted by a single person who is the same person doing the analysis, as in this study. There is a number of ways to try to limit the potential for bias arising in such a case.

Brink (1991:172) recommends the use of a "judge panel", that is, a panel of experts who assist at various stages of the process. She suggests that this is of particular value when the researcher is a stranger to the context of the study. In the present study, the researcher was familiar with the general context, though not with the individuals who made up the specific population. She had been a student nurse herself, and had spent many years working with and teaching students nurses in a variety of settings and institutions in three countries. Intuitively the researcher felt that the data elicited, and the analysis as it developed, were a good fit. This familiarity, while it was useful, was also a potential source of preconceptions, and it therefore seemed useful to have some judges whose expertise was in research and education rather than nursing. Academic supervisors were familiar with all three spheres, as were fellow postgraduate students with whom many useful discussions took place, but in addition, colleagues from other areas of educational research were called upon. There was not a panel as such, but rather a varying selection of individuals that suited the needs at various stages in the process. Such tactics served as a check on the credibility of the developing theory based on the reported data. It did not, of course, offer a check on the validity in terms of whether the theory actually told the story in a way that was faithful to the self-perceived meanings of the students.

It is often suggested that a useful way of testing the validity of grounded theory is to take it back to the subjects to see whether they agree that it fits or feels right to them. This idea was considered but rejected. Because the phenomena being studied changed as the students moved through their training, and in fact it was the change that was of particular interest in the study, it seemed clear that they would go on changing. This meant that at whatever point further contact might be made with the students, the views gleaned from them at that time would be less a check on their previous perceptions than simply a new layer of changes in their perceptions. This was particularly shown by the frequency with which, by their third interviews, they could not recall accurately the views they had expressed in their initial interviews. For these reasons, the notion of taking the theory back to them for validation was rejected.

In the end, it had to be accepted that nothing further could be done to increase the assurance of validity. It was felt, however, that the attempts made had established it as far as possible within a study of this size, with the resources available.

Approach to Analysis of Interview Data

The analysis of the data entailed the use of constant comparison in the process of coding. In carrying out the analysis, a number of sources were used for guidance. These included, in addition to Glaser and Strauss's own seminal reference (1967), Glaser (1978), Chenitz and Swanson (1986), and Strauss and Corbin (1990). The usefulness of each source varied at different points in the analysis, as is indicated in the following discussion. In this section, the experience of employing the analysis procedures is discussed, and they are illustrated with examples from the data analysis.

DISCOVERING THEORY THROUGH COMPARATIVE ANALYSIS

The method recommended by Glaser and Strauss (1967) for discovering grounded theory involves examining every piece of data as it is collected and comparing it with other data. In the case of this study, this would mean looking at the transcript of the first interview conducted, then comparing it with the transcript of the second interview in detail to look for categories or patterns that existed. Codes would be assigned accordingly. This would continue with each subsequent interview, and the categories would increase in number and fill out.

In the early stages of data collection, I found this to be impossible, for two reasons. Firstly, it was a practical impossibility. As I was working at a busy full-time job I only just managed to fit the interviews in, in the relevant time period. I was unable to transcribe them immediately after they were conducted, and therefore I could

not carry out formal detailed comparison of data at that time. Secondly, I found that when I did examine the transcripts in detail, I didn't seem to be able to do what was required. As I looked at the data, it was as if I couldn't see the forest for the trees. Anything I could identify in the way of categories, properties, patterns, etc, seemed to be so trite or predictable that it was hardly worth speaking about. I became quite discouraged about using the grounded theory approach at that point, as it appeared that it was not going to enable me to achieve what I wanted.

In time, this situation changed and many of the apparent problems seemed to resolve themselves. For one thing, there was actually more analysis going on in the early stages than I was aware of at the time, partly at an informal level in my head. This was evidenced by the fact that I made choices for theoretical sampling that were based on ideas of emerging theory. These choices influenced the selection of student subjects from the second and third groups, and motivated certain changes in the direction taken in the interviews themselves. In addition, I made numerous memos, both theoretical and methodological, throughout the period of data collection. It later became apparent that these were highly useful in the formal analysis.

The richness of the data from the first-round interviews became more evident as the second-round interviews progressed. Some of the things that seemed so trite at first gained appreciably in meaning. An example which will illustrate this was a broad theoretical theme which developed as a working category with the title "The Good, The Bad and The Ugly".

In the first round of interviews, one topic area that regularly came into the conversation had to do with what the student imagined as the best things and the potentially unpleasant things about nursing. These came into the conversation in different guises but were always present in some form. Some students, for instance, described what they believed to be the things the nurse would gain satisfaction from, while others talked about what would make a person want to do nursing. The unpleasant things were sometimes mentioned in relation to reasons nursing wouldn't be suitable for some people (those who couldn't put up with the unpleasant things), or sometimes in relation to things the individual student expected would be difficult for herself/himself.

In carrying out open coding of data related to this topic area, I assigned conceptual labels to the categories in the following way. There were interrelated ideas that had to do with images of the positive aspects of nursing work:

- seeing people get well;
- making people more comfortable;
- getting thanks;
- feeling a sense of achievement;

- feeling you have done a good job.

I placed these in a theoretical category called “the good”. Similarly several interrelated ideas had to do with images of negative aspects of nursing work:

- having to deal with death;
- having to talk to people who are not going to get better;
- having to talk to bereaved relatives;
- seeing people suffer;
- having to do dreaded tasks such as injections.

These made up a theoretical category I called “the bad”.

When these categories appeared during the first round of interviews, it hardly seemed worth identifying them, because they seemed so obvious and predictable. Their meaningfulness only emerged as data were gathered in the second round of interviews.

When discussing how nursing as they experienced it compared with their initial images of nursing, students were asked about the positive and negative aspects they perceived. Their responses indicated that their images of what was satisfying and rewarding about nursing work had indeed agreed with their experience, and did fit the theoretical category of “the good”. A subtle change had taken place, however, in “the bad” category. Some students had not yet encountered experiences such as those in their initial images, and they were therefore unable to comment on the associated reality. Those that had encountered such experiences had found that although some of the experiences were unpleasant or difficult to cope with, others had features that kept them from being altogether bad. In fact, there were cases of “bad” components of their image virtually moving into the “good” category, because some such situations had provided opportunities for feeling a sense of personal achievement, or for seeing improvement in a patient they were caring for, or for having their efforts appreciated (e.g. if they were able to make a dying person feel more comfortable).

An interesting finding in this area of the data was the appearance of a third related theoretical category to which I assigned the working label “the ugly”. When students were asked about aspects of their work that had been the most unpleasant or most difficult to cope with, the incidents and ideas they recounted provided data in which a new set of concepts was identified. These included:

- 1) Unsatisfactory relationships with staff, e.g.
 - staff making students feel unwelcome;
 - staff not supporting and teaching students to the extent that students feel they need it;

- staff not working with patients, leaving students to work on their own;
 - staff not giving students enough feedback to know how well they are doing.
- 2) Having to interact with patients who are uninformed about their conditions, e.g.
 - a patient with terminal cancer not knowing her diagnosis, although all the staff and relatives did — the student felt she had betrayed the patient’s trust;
 - patients to have investigations not knowing what they are, and when they ask the students about them, the students not having enough knowledge to tell them.
 - 3) Not having adequate support to meet students’ own needs, e.g.
 - not having enough opportunities to discuss difficult issues, such as caring for the dying, caring for teenagers who have had abortions;
 - having no clubs, sports facilities, yoga classes, etc — students in other colleges have such things.

I thought at first that this data represented additional material for “the bad” category. As time went on, however, and the related items increased in number and variety, I began to see that there were some significant differences between these and the substantive items in the original “bad” category. These included the following properties:

- 1) None of the newly discovered negative items formed part of students’ initial images of nursing, so whereas the “bad” items were anticipated, these new items were not.
- 2) The new items represented aspects which are not inevitably a part of nursing. Indeed, there were often contrasting examples offered in which opposite situations existed, such as: wards in which staff really made students feel welcome, gave lots of support and teaching, etc; cases in which interactions with patients were rewarding because patients were dealt with honestly. The “bad” items, on the other hand, seemed to be natural and unavoidable parts of nursing work.
- 3) The “bad” items, although difficult to deal with and sometimes sad, could be seen to fit with students’ personal sets of values. The new set of negative items conflicted with those values.

For these reasons, I decided that these newly appearing negative items constituted a new theoretical category, and “the ugly” came to mind as a usefully descriptive working title for it. However, in the final analysis, “the ugly” was re-merged with “the bad”, for two reasons. Firstly, the notion of “the good and bad” evolved as an organizing theme that applied to virtually all the data in some sense. Secondly, it was decided that rather than representing a different theme, the elements of “the ugly” represented

development in the students' images of what constituted "the bad". In other words, they were part of the experience-mediated image of "the bad".

As illustrated by the above example, comparison between pieces of data and exploration of interrelationships were carried out until all data had been analyzed.

PROPERTIES AND DIMENSIONS

The emerging categories were examined and compared, concepts identified, and categories described in terms of their properties and dimensions in the process Strauss and Corbin refer to as open coding (1990:61-74). Not all categories could be dimensionalized as indicated by Strauss and Corbin, because not all properties could be located along a continuum. Such categories had properties that might be seen as analogous to nominal measures in quantitative analysis.

The category of "staff", which developed from data from second- and third-round interviews, had a number of properties that were capable of being dimensionalized. Three of these can be diagrammed as illustrated in Figure 4.5. It can be seen that these

Figure 4.5

Dimensions of "staff"

Supportiveness to students

Recognize students' need for support and take measures to provide it.

Neither recognize students' need for support nor try to provide it.

Welcoming-ness

Make students feel welcome in the clinical area.

Make students feel unwelcome in the clinical area.

Sharing in the work

"Muck in" with the work; work with students.

Stay in office; always doing paper work; leave students to do all the work.

three properties can appropriately be placed along continua, as the potential for classifying staff on each of the measures is infinitely variable.

One category whose properties did not lend themselves to dimensionalizing was "pictures of nursing". In describing their mental pictures of a nursing scene, students tended to offer descriptions in which there were two or more discrete characteristics possible. For example, they described the physical context of their pictures as either an old-fashioned open ward or a modern ward with small rooms. In giving an account of the people in their pictures, they offered any or all of: patients, nurses (sister, staff nurses, students), visitors, doctors (trained and students), other health care workers, and/or other people they could not identify. The activities going on in their mental picture included conversation, TPRs being taken, medicines being given out, doctor's rounds, and bedmaking, as well as jobs that they could not identify. These three properties of their pictures (physical context, people, and activities) consist of measures that are not describable as degrees of a dimension, but as discrete components or attributes, and they therefore cannot be illustrated conceptually as being on a continuum.

DEVELOPING RELATIONSHIPS

As the coding progressed, relationships between categories were identified. In doing this, Glaser's advice (1978:74) on asking questions about the data was helpful, using families of theoretical codes to frame the questions. Corbin's advice (Chenitz & Swanson 1986:91-101) on linking categories also provided helpful ideas.

Strauss and Corbin's guidance (1990:96-115) on axial coding was less helpful. They offer a coding paradigm which they imply should be used universally in the analysis of grounded theory data. This paradigm, however, while it seems eminently suited to the example they use, does not seem to fit the data in this study. Strauss and Corbin indicate that the researcher should

link sub-categories to a category in a set of relationships denoting casual [sic] conditions, phenomenon, context, intervening conditions, action/interactional strategies, and consequences (1990:99),

and this constituted their paradigm model. Although they state that a phenomenon is a "central idea, event, (or) happening", their model seems not to fit many elements of a study of mental images. It seems to assume the observation of "real" events or phenomena, whose antecedents, contexts and consequences can also be observed. This is not the case when the phenomena being explored are perceptions, when "real" reality (as opposed to the informant's perception of reality) is not the researcher's area of concern.

Thus in this study substantive categories and sub-categories were identified, and relationships between them were sought, regardless of the nature of those relationships. Many of the relationships emerged during the second- and third-round interviews, as movement within conceptual themes became evident. One type of relationship existed in the nature of the movement that took place, and this appeared to be related to psychological processes the students went through as they encountered the reality of their experience of nursing.

An example illustrates this. One element in a student's initial picture of nursing might have been "interaction". That is, she may have had a mental picture in which nurses were talking to patients. In addition, she might have indicated that communicating with patients was a central element in her image of what nursing consisted of. This may have been elaborated with ideas of why communication was important. In a later interview, this student might indicate that she had not perceived much communicating going on in her experience of nursing so far. The relationship between this apparent contradiction between her initial image and her perception of experience might hinge on any of a number of processes, depending on how she expressed her reaction to this contradiction. She might, for example, indicate that she recognized the difference but rationalized it on the basis that the wards she had been working in were excessively busy and/or understaffed. Thus she might retain her initial image in this regard, but still acknowledge that what she had experienced did not agree with it. On the other hand, she might indicate that nursing was not as she had pictured it, because nurses did not really communicate with patients. In other words, she might decide that her initial image had simply been wrong in this regard, and replace it with a revised image based on her perception of her experience.

In this example, the links consisted of processes by which the students dealt with contradictions between components of their initial images and components of their experience, leading to the formation of their experience-mediated images. These links themselves then became theoretical categories, but at a higher level of abstraction.

SELECTING THE CORE CATEGORY

In the earlier stages of data analysis, it appeared that the most central categories comprised the conceptual themes that arose from the data from initial interviews and then demonstrated movement as the second- and third-round interviews progressed. However, as the themes were explored and the "story line" explicated (Strauss & Corbin 1990:119ff), it gradually became clear that perhaps more central were the processes by which the movement was taking place. The search for the core category then centered on locating the common focus of the processes that occurred.

Note on Presentation of Data

A number of choices had to be made about the presentation of data from the interviews. These included the order of presentation, the amount of direct quotation, the form of quotation, and the mechanisms used to indicate such features as omissions and nonverbal aspects. This note describes and explains the choices made.

THE ORDER OF PRESENTATION

It was decided to intersperse interview data with discussion of the data, including a basic level of analysis. Further analysis, at a higher level of abstraction, is discussed later.

Data from the first round of interviews were treated as if they represented static phenomena, which, of course, they did not. They actually represented something like a snapshot of the students' images at a particular point in time, and the themes that arose from the data underwent movement and change over time. However, presenting them as if they represented static phenomena provided a base from which to work, when analyzing the movement and change as represented by the students' accounts in later interviews.

The second and third round interview data were not treated separately, for two main reasons. Firstly, their purpose was to provide evidence of the development of students' images from their initial form through to their experience-mediated form, and both the second and third interviews took place when students had had such experience. Therefore they were not different from each other in the same sense that they were both different from the first interviews. Secondly, the students undertook their clinical modules in three different orders, and the types of modules they all eventually had in common, that is, medical and surgical nursing modules, some had as their first and second modules while others had as their third and fourth modules. Thus it made no particular sense to separate the discussion, for most purposes. On the rare occasions when it was significant to the discussion, this has been mentioned.

QUOTATION

Because the primary data in this study consisted of interview transcripts, it was impossible to summarize it for presentation in tables, graphs, or the like. This is, of course, typical of a qualitative study. It was necessary to provide enough evidence to enable the reader to assess the researcher's interpretation, and the validity of the theory derived from the data. On the other hand, excessive quotation had to be avoided, both because

it would be tedious to read, and because it might obscure the focus on the salient features of the accounts.

This was a delicate balance to strike. At some points, quotation is presented in considerable detail, while at others it is less so. Such variation depended on the need. For example, at some points it is helpful for the reader to see the interviewer's questions and prompts in order to comprehend the full meaning of a student's account, while in other cases an extract of a student's own words suffices. Thus there is a certain amount of inconsistency in the amount of quotation, but this is deliberate.

The interviews were transcribed verbatim, and thus it was possible to present as much full quotation as desired in the discussion. There is, of course, a limit to the degree to which the spoken word can be represented accurately on paper. It had to be decided how faithfully the students' exact accounts should be represented.

As is always the case in informal conversation, students did not tend to speak in full sentences, complete with punctuation indicators. Their accounts contained repeated instances of "um", "er", "like", "ken", "you know", and "I mean". It was decided only to leave these in when they added something valuable to either the meaning or the flavour of an account, and to punctuate accounts in such a way as to convey the appropriate meaning.

Many students spoke in dialect. This had implications for pronunciation, semantics, and grammar. Typical pronunciation characteristics included saying "mair" for "more", "fit" for "what", "about" for "about", "recht" for "right", and the dropping of the "g" sound from words ending in "-ing". For the most part, these have been represented as they were spoken, unless it was thought that their meaning would not be clear; in such cases they have been represented as in standard English.

Semantics presented quite a challenge. Students sometimes used local Scots words, such as "bozie" for a cuddle, or "asht" for a dinner plate. Sometimes English words, or versions of them, were used in a locally idiomatic way, as in the use of the phrase "the morn's nicht" for "tomorrow night", or the use of "gotten" as the past participle of "to get" (correct in American usage, but no longer used in standard English) and "putten" as the past participle of "to put". Again, these have been represented as they were spoken, as long as the meaning seemed to be clear. When it did not, they have been either translated and put in brackets, to indicate that a word or phrase was not the student's own, or, if necessary to the flavour of a quote, they have been left in and a translation provided.

Many students used grammar in an idiomatic way that was typical of the local spoken language but would not have been considered correct in the written language. For example, it was quite common to find inconsistency in number between a subject and verb or between a noun and its modifier, as in "they wisna gan" ("they wasn't

going”), or “all this patients”. The problem here for the researcher had less to do with the reader’s understanding than with the reader’s judgement of the student who was being quoted. Again it was decided to remain faithful to the students’ accounts, as long as they were understandable, so few changes have been made in this regard. The reader is asked to keep this in mind, and not to misinterpret apparently bad grammar as indicating that a particular student is either unintelligent or uneducated.

CHANGES, OMISSIONS, AND NONVERBAL ELEMENTS

One of the first changes that had to be made was in the names of the students. To protect their anonymity, as promised, they were all given code names. No actual name of any student was used as a code name for any other. In parts of the discussion where dialogue is recounted, just the initial of the student’s code name has been used, as have the initials “AK” for the interviewer. For example, if an extract of an interview with “Eileen” is being discussed, and a portion of dialogue is quoted, it takes the form

AK -

E -

Other measures have been used throughout the quotations to protect the students’ anonymity and that of other persons and places they mentioned. Names have been substituted with a designation in square brackets. Sister Smith, for example, would appear in a quotation as “[ward sister]”; a ward called Queen’s Ward might appear as “[medical ward]”. Certain items of information mentioned by students were also sometimes changed if it was thought they might give away a student’s identity. For example, if a student had done a course in hotel management, and then worked in a hotel job before coming into nursing, this might appear as “[previous unrelated course]” and “[job in service industry]”. Alterations were not made when such a feature was nonspecific or common enough not to identify the student, such as when a student indicated an interest or experience in another occupation that was also mentioned by a number of other students (as happened with police work).

There were many instances of deletion of a portion of a quotation when it was irrelevant to the point of a discussion. Such deletions have been indicated with brackets and dots: “It was my first ward, (...) the staff there were really good.” Pauses during a student’s account have been indicated with a series of dots not enclosed in brackets: “I just thought ... well, I expected staff to be nicer to students.” Interruptions are designated by a long hyphen:

AK – What do you think—

St – I always imagined a nurse would

Occasionally there was a nonverbal or extra-verbal feature of an account to be indicated. This was done with a word or phrase in square brackets. Often this was a laugh, or a particular tone that was apparent. Clearly, the interpretation of a tone was subjective on the part of the researcher, but it seemed important to include this in certain cases to increase the reader's understanding, or to avoid a misunderstanding. A student might have spoken in a wistful tone, for example, which might give a poignancy to her words that would not otherwise have been apparent. Or a student might say something in a joking tone, so that the words were actually the reverse of the real meaning.

Inevitably, many features of an interview are lost as it is transferred to a written account. Important nonverbal elements do not even survive the transferral to the audio recording. Often an attempt was made to capture such elements of the accounts of students in this study via written notes, describing a student's facial expressions or posture, for example. It is impossible to record all the fine points of such features, and many others that related to the spoken account itself, such as exact inflections and tone of voice. However, it is hoped that the discussion in the following chapters, including the selected quotations, have captured the the meanings and flavour of the students' accounts sufficiently to serve the purpose of the study.

PART 3

THE IMAGES

Chapter 5

BEGINNERS' IMAGES

In this chapter, themes that emerged from the first round of interviews are discussed. They are considered under five major headings:

- pictures of nursing,
- the good nurse,
- images of what nursing entails,
- occupational labels for nursing, and
- being a student - becoming a nurse.

Discussion under each heading is further subdivided as appropriate.

PICTURES OF NURSING

In the first few interviews, when students were asked how they saw nursing or what their idea of nursing was, some described a typical scene. In subsequent interviews, students were asked more directly to describe a typical scene or picture they saw in their mind's eye when they thought of nursing.

As students' "pictures of nursing" began to take shape, some complications became apparent. For example, although all first interviews took place before their first clinical allocation, some students had observed in wards during their introductory course and described two pictures: an entry picture and a current or revised picture.

Other students described one typical picture of nursing, and then described another of a specific type. This was a particularly interesting phenomenon, because in all but two cases, their typical pictures were of a general ward, regardless of which type of training they had come to do. Few of the non-general students noticed the oddity of this until it was pointed out to them. They then described another mental picture of nursing in their chosen field, a specialist picture.

Some students also recalled a childhood picture as differentiated from their entry picture. And finally in this theme, "picture of a nurse" became apparent.

The discussion begins with "typical pictures", that is, the first pictures students offered in response to the initial question. The other component themes are then discussed: "entry pictures and revised pictures", "specialist pictures", and "picture of a nurse". (It should be noted that a student's "typical picture" was not necessarily separate from her other "pictures".)

Typical Picture

Typical pictures were usually set in hospital wards. Most of these were Nightingale-style: "a big ward wi' wee side wards" (Valerie), "an open ward full of beds" (Angela), "an old-fashioned ward with rows of beds" (Kathy). Donna commented that "I never really pictured a ward with cots until I went to see one the other day," even though she was doing Sick Children's training.

Exceptions to the picture of a big open ward were few. Gail saw a "modern type ward"; Eileen saw a ward with six beds; Ian saw rooms on a long corridor, with people walking in and out; and Sarah saw a choice of two, one being the "long wards with all the beds" and the other being an "American style ward" with a main desk and separate rooms. The only non-ward picture, offered by Julie, was a sitting room scene such as one might see in an adult training centre or holiday house for long-term patients.

Within their pictures of these settings, students described physical features, characters and activities. Some students saw these in remarkably clear detail, while in other cases the picture was more blurred and vague.

Some students' pictures were populated with only patients and nurses, while others included doctors, auxiliaries, cleaners, visitors and receptionists. The students' view of the patients was interesting. Many saw the patients all in their beds. Few were able to say anything more descriptive about them, except occasionally to refer to the types of things that were wrong with them. In Malcolm's picture, the patients had "broken legs and things", in Gail's they had plasters on their limbs and legs up in traction, and in Donna's they had fevers or were going for surgery. Some students also mentioned the age ranges of the patients. Gail saw mostly young adults, and Carol and Mary Ann saw "mainly old folk".

Carol and Rachel both mentioned that the patients were not happy: "no smiling faces", as Rachel put it. Otherwise, patients seemed to be faceless and personality-less. Sarah offered the following graphic description:

S - It's just really the nurses that stand out more than anythin'. You know there's patients there because they should be there, but you don't really see the patients (...) it's like a photo when you cut off the sides and you just get that much of the person, you don't see any more. There's a bump in the bed but it could be anything.

Sarah accompanied this account with gestures indicating the position of the beds up and down the sides, and the cutting off of the photo's edges, taking away the heads of the patients lying in the beds and leaving the viewer to see only the "bump" in each bed.

Reflecting a similarly depersonalized view of the patients, Donna said that "you just think of them as patients, not real people." Rachel saw them

R - in the background. (...) as a mass, they're just patients, and not individuals.

These similar views might suggest that these students entered with a predisposition to be unaware of patient individuality, which in turn would suggest that when disregard of individuality occurs (as in "the pneumonia in bed 5"), it may not be entirely the result of socialization during training.

Few students saw patients as being anywhere other than in their beds. Mary Ann thought some were sitting beside their beds, and Angela thought some might be going to the TV room or to the toilet or bathroom.

Nurses were usually noticeable in the ward pictures. Specific details about them are covered in the "picture of a nurse" section, but few aspects are relevant to the discussion here.

Tina saw the ward as having a structure that was "like a class system". Doctors were at the top, with nurses and patients below them, nearly level with each other, the nurse being just a bit above the patient at times.

Some students just saw nurses in general, whereas others saw different grades of nurse in the picture. Sometimes "Sister" was mentioned, and was described quite differently from the rest of the nurses. Nurses were usually busy, "doing chores" (Zena), "milling around" (Helen), "futterin' around a few patients, tendin' to their every whim" (Donna), or "trying to help people" (Carol). A few students had specific ideas and saw nurses "administering medicines" and "getting patients out of bed" (Angela), "doing dressings" (Valerie), "dashing in and out with trolleys and bedpans" (Kathy), "fluffing up beds" (Gail), "clearing up somebody's sick" (Natalie), "seeing who needs painkillers" (Malcolm), "taking pulses or temperatures" and "feeding" (Mary Ann), "speaking with patients" (Eileen), and "listening to patients" (Julie).

Natalie's picture did not at first appear to show the busy-ness to the same extent as others:

N - There'd be a few staff about (...) in the background. (...) They would be, I suppose, doing some things, or they'd be chatting to the patients. I didn't think they'd be particularly busy. (...) They may be busy, but they don't look like they're rushing about, they're quite cool. Unless there's some emergency going on, or something like that.

Sister, when she appeared in the picture, seemed to be less busy than the other nurses were. She was, as Sarah saw her, "sitting writing at a desk," and, according to Rachel, "sitting at the top looking stern, not doing an awful lot." Yvonne said that in her picture Sister was "in the middle of the ward (but) I don't know what she's doing."

A variety of other elements came into students' typical pictures. Zena said that she saw a bright, white and clean Nightingale ward with lino on the floor, and it felt happy.

The atmosphere in Kathy's ward was efficient and clinical. Donna's ward was in a "nice white hospital" and it was "sparkley clean" with "nothing out of place." In contrast, Rachel's picture was of a ward that was black and grey, although there might be some daffodils to be seen. Yvonne's ward was similarly dark and plain, with no colour, and it was full of noise. Angela's ward was busy, with "everyone hashing around." Natalie saw a ward that was formal and organized, with beds neatly in a row.

Mary Ann described her ward as having "quite a good atmosphere." It was calm, "everyone's settled, hopefully nae havin' too bad a time in hospital." The ward in Carol's picture had white walls, with curtains round. Unlike Mary Ann's ward, though, it was not a happy place, though the people were nice, because "if you're a patient, it's horrible." This feeling was echoed by Rachel, who said that in the ward she pictured, people were "terrified to move". There was a frightening atmosphere for staff and patients as well (seemingly something to do with Sister).

Perhaps the most detailed description came from Sarah. In her picture, the ward was white, there was no equipment around, and it had a warm feel to it, in relation to both the temperature and the nurses. "I'm beginning to smell it now, thinking about it," she said. The patients in her picture had had their independence taken away and were living according to the ward routine, unlike in "real life" where they had been "doing their own things," but she supposed "you have to have rules like that."

Entry Pictures and Revised Pictures

Some students differentiated between the pictures of nursing they had had when they entered and the pictures they had by the time they were speaking to me, one week to four weeks later. None had actually worked in clinical areas as students at the time they were interviewed, but some had seen wards and some had found their ideas changed as a result of what they had been hearing from teachers in college or from more senior students.

One type of change that occurred was in the physical setting of the scene. For Zena, Mary Ann, and Yvonne, the picture became one of smaller rooms, rather than a big open ward. Zena's feeling was that this was more homely; for example, it had carpeted floors.

A major change for some students was in their view of the patients. Helen now saw patients as "demanding, needing help", and said, "They will get out of bed, I would expect them to stay in, before." Donna gave a detailed account of the change in her picture:

- D - (The patients) sort of come out more like people. I mean, before you get round the wards and that, you just think of them as patients, not real people. That's

all. But I mean, they get up, they can do things for themselves, they can tell you, they need personal belongings, things, they need special care, individual care, not just care per ward, it's care per person. (...) They're all doing their own individual things, They could be up, they could be walking around, even if they've just had an operation, they could be helped walk back and forth in the ward, just a little bit, they could be making something, knitting, calm, reading, just anything that they wanted to do, some are sort of lying there watching the telly or something.

Some of the students now saw a greater variety of people in their pictures. Helen had visitors in her new picture, and nurses divided into different grades. Donna's revised picture also had various grades of both doctors and nurses, including students, and now had receptionists as well. The staff personalities she had imagined had changed from being "a whole lot of nicey-nicey do-gooders" to being

D - just like normal people that you would find in any other job, (...) funny ones, normal ones, ones you don't get on with at all, ones that you chum about with.

The population of Rachel's picture had undergone a more considerable change. The picture she had "even a week ago" had changed as a result of a day's visit to the geriatric hospital.

R - She's part of a team. I didn't realize that she was part of a team. Yesterday we were up in [geriatric unit], and it was physiotherapists, dietitians and that, and you could see them workin' as a team, and it was really amazin'. (...) They've been goin' on about bein' part of a team, but I didn't actually think (...)

AK - Supposing I had asked you a month ago the same question, a picture, can you remember what it would have been like?

R - Someone runnin' around with bedpans. The only person involved in lookin' after the patient. (...) It would be a Nightingale ward, up and down, and back and forwards to the sluice. (...) There certainly wouldn't have been physiotherapists and that sort of thing. (...) Really strange, I really opened my eyes yesterday. (...) I think I see (patients), but not as like an individual, I mean, that is what's been drummed into us, individuals, you tend to think that ... as a mass (...) and not individuals, but certainly now ...

Rachel seemed to be very aware of what "they've been goin' on about" and "what's been drummed into us," but indicated that it was the visible evidence that brought things home to her, rather than the reiteration in college.

Rachel indicated that in her original picture the doctor was in charge, whereas now her view was that "everyone knows the sister's in charge," but "somebody looking from the outside would think it was the doctor that's in charge." This shows a change in her picture and also suggests something about where she felt herself to be in relation to the picture. She seemed to be moving from an outside to an inside view of the profession. Another comment illustrates this:

R - The doctors ... I like the way the tutors an' that talk about them, you know, like they say that they think they're all know-alls an' that, but they're actually just pains in the neck, so ... I like that. [laughs]

She seemed to be happily identifying with the attitudes she perceived as being exhibited by her “tutors an’ that” towards doctors.

In Helen’s revised picture, she had a more precise idea of what she thought people were doing. She now saw a ward that was “very busy, a lot happening”, with nurses “making beds, and bedpans [laughs]. (...) if it was like surgical day, they’d be getting them ready for surgery.”

For some students, the atmosphere in their revised picture differed from that in their entry picture. Helen saw it as brighter, and Rachel saw it as a happier place, with people more at ease.

Carol’s picture seemed to have been revised quickly, as it was only Monday of her second week in training when she was interviewed. The two pictures seemed to have a lot to do with her own experience as a patient and a visit which her Introductory Course class had made to a geriatric hospital ward.

AK - Supposing I was to ask you, maybe before you came in, to draw a picture of a nursing scene, what would be in the picture?

C - Eh, just walkin’ about wi’ a white uniform tryin’ to keep patients calm, an’ helpin’ them, cheerin’ them up. (...) in a ward somewhere (... with) mainly like white walls, an’ the curtains that come roon’. It’s a bit like a Nightingale ward, with the beds runnin’ up an’ doon, but we was in the [hospital], an’ it wisna’ like that at a’. It was new an’ it was nice, so ‘at’s different again fae fit I thought it would be like. So it was a pleasant surprise. [laughs] (...) It seemed a lot happier, the wards themselves, the patients seemed happy, (...) it looked neat an’ tidy an’ clean an’ the patients looked happy, an’ the nurses was just basically there keepin’ the patients happy. So it was nice. (...) I’ve once been a patient an’ it was horrible. The people in the ward I was in was nice, but I didna like it, an’ ... I was glad to get oot, but these folk seem happy. (...) An’ there was cats walkin’ about, which came as a surprise. Cause people said that there was cats, an’ I thought, “Oh, aye” [tone of disbelief]. But then then the first thing you did when you walked in was you seen this big cat lying on a bed an’ you thought, it’s true. I mean, you dinna usually associate hospitals wi’ cats an’ things.

It seemed that in both her entry and revised pictures people were nice and trying to help, but it seemed they were not being successful in this in her initial view, whereas in the revised version they were. The improved atmosphere in her revised picture seems to have something to do with unexpected informality.

In Yvonne’s entry picture, nursing staff had been wearing longish old-fashioned uniform dresses with cloaks and hats, but in her revised picture, the staff were in plain uniform dresses. The other change was in her picture of Sister:

AK - And in the old picture you had (...) who would you have seen in that picture?

Y - The sister [laughs], the crabby sister. Sometimes it scares me, like I’ve just had this thing that, like, all sisters are dour and get you into trouble and things, you know, and I thought, Ooooh! But, em, they’re not all like that. (...) [A teacher] was telling us about when we go out (...) it was her that was saying that they’re not all horrible, and there’s nice ones.

It seemed clear from these accounts of entry and revised pictures that it hadn't taken long for initial images to begin to alter. This early in their training, students were still capable of remembering the pictures they had had as they entered training and recognizing what had altered since then. Carol showed this at the beginning of her interview:

AK - First can I ask you, have you got a picture in your mind of what nursing's gonna be like, a sort of scene?

C - Well, before I came here I probably did. Oh, I just thought it was, you was out in the wards, and you were just tryin' to help people, but since I've been at college, my views have totally changed.

Helen's account of the changes came about this way:

AK - Is that different from what you might have said (...) the day before you came to start your training? (...)

H - Yeah [no hesitation].

AK - Can you remember what it would have looked like?

H - Well, all the patients just lying in beds, and the nurses, I don't know, busy doing something else ...

Donna seemed to have rather more difficulty searching her mind for her entry picture, after four weeks in training:

AK - ... can you imagine what that picture would look like? What kind of place would it be?

D - It would just be ... em ... well, it's quite difficult now I've been round the wards and everything. (...) It's quite difficult, I'm trying to think of before, before I came, you know ... em ...

She went on, however, to give quite a detailed description of her entry picture, and differentiated it from her revised one. Despite her expressed difficulty, she offered the fact that a difference existed without prompting, and the account she gave seemed genuine and spontaneous.

The ideas that emerged as a result of examining the data relating to entry pictures and revised pictures and their relationship with each other constituted a theme that showed further change in second and third round interviews, as is discussed later.

Specialist Pictures

There were students doing general, mental handicap and sick children's nurse training among the twelve interviewed from the first intake group. Curiously, all offered pictures that were clearly of general nursing as their typical pictures.

Valerie, who was doing mental handicap training, described the activities going on in her picture as "talking to patients, doing dressings, and a doctor doing his rounds." Later on, in the context of a different theme, she said:

V - I don't really want to work in a hospital, it's more an adult training centre, cause I'm doing mentally handicapped nursing.

AK - Oh, right. Now, that's interesting, because when you said your view of nursing, it was still in a hospital ward, isn't it, but you don't want to be in that bit of it?

V - No. [laughs]

Thus Valerie seemed to accept the incongruity of the fact that her typical picture of nursing was a general one rather than a picture of the type of nursing she wanted to be involved in.

Helen, who was doing sick children's training, gave entry and revised pictures that were both general in character. She never mentioned anything that could be considered to indicate that the pictured ward was for children. Cots were not mentioned, for example, nor were children or parents. She did allude to her specialty field in the context of her concern with having to cope with a child's death, but there were also occasions when she alluded to geriatric wards and to mentally handicapped patients.

Because of this apparent tendency to picture general nursing as typical regardless of a student's chosen field of nursing, a particular effort was made to include students doing psychiatric training in the sample selected from the second intake group. Among those, Mary Ann, like Helen and Donna, gave no indication of her chosen field in either her "entry" or "revised" picture. The incongruity was pointed out to her later in the interview.

AK - Something curious, you've been telling me about your picture of being a nurse, and your nurse has been in a uniform with a white hat, and it's been in a ward sort of setting, with patients, mostly older folk, on their beds or by their beds ... you're coming in to do psychiatric nursing.

MA - Uh-huh.

AK - Is that, does that picture fit the nursing you're going to do?

MA - No.

AK - So you've got a separate picture of psychiatric nursing.

MA - Aye [slight laugh].

AK - What's it like?

MA - Well, it's mair sorta casual, I mean, probably if there's uniforms, well, there's no hats 'n that. Even maybe just sometimes ordinary clothes an' a' that. (...) nae s'much beds 'n blood pressure an' a', it's mair like maybe helpin' folk dee things, like knitting, or somethin', gardenin', somethin' like 'at, mair that sorta picture.

Mary Ann seemed able to identify several differences, albeit fairly superficial and vague, between her two pictures.

Sarah, too, was doing psychiatric nursing, and gave a typical picture that was very much general in character. In addition, a number of things she told me about herself implied a view of nursing that was general. She described an avid curiosity about ambulances and accident and emergency departments, and told me about wearing a play nurse's uniform as a child. She, too, was asked about the apparent incongruity between her typical picture and her choice of nursing field:

AK - You're doing psychiatric nursing, aren't you?

S - Yeah, yeah.

AK - And does that picture fit your idea of the nursing you'll be doing?

S - No.

AK - Have you got a picture for that?

S - Well, I see that more as, just like sittin' round talkin' to people, in a group. And there would maybe be a couple of nurses, but they're not wearin' uniforms or anythin' (...) carpets on the floor, an' chairs just like this [our chairs, with soft seats] (...) It could be anywhere, it could be sittin' in a community centre, and things like that. (...)

AK - When I asked you, I didn't say what kind of nursing (...) and the picture you gave me wasn't psychiatric nursing ...

S - No, it was just general.

AK - Does that mean that you've chosen ... something else, you've deliberately chosen the other picture for yourself?

S - Yeah.

Natalie was doing sick children's nursing. Unlike the previous non-general students interviewed, she did not offer a typical picture that was specifically general, nor did she require prompting to describe features of the picture that related to her specialty field. When asked what the scene in her picture would look like, she said:

N - Well, it'd be in the ward, I mean, in the children's hospital, it's very relaxed, and informal, so, it's not such a hospital environment over there. (...) it's very informal, but I think in the hospital, it's a lot more formal, you know, beds neatly in a row.

AK - Uh-huh, OK. So if you think of, when you say, "if it's in the hospital" are you meaning —

N - Sorry, in the main hospital. (...) if I was just thinking of an ordinary hospital, it would still be a very formal picture.

Although Natalie readily offered a picture which related to children's nursing, she still seemed to feel it was atypical, because she was clearly referring to adult general nursing when she said "in the hospital", "the main hospital", and "an ordinary hospital". It would seem that to her, sick children's nursing was not in the mainstream and was not ordinary. Another interesting feature of her description is that, like Mary Ann and Sarah, she pictured her chosen specialty field as being less formal than adult general nursing.

Malcolm, in the third intake group interviewed, had elected to do mental handicap nursing. His typical picture was clearly a general one, and again, his view of this as typical was addressed in the interview:

AK - Now that's an interesting picture, because you're coming in to do mental handicap nursing, aren't you?

M - Yeah. [laughs]

AK - So, does what you're coming in to do fit in that picture?

M - No, this is, this is my, just, when I think of the word "nursing," that is just what I see. I just think ward nursing.

AK - Right, so when you think "mental handicap nursing"—

M - I think it's completely different. [laughs] (...) It's a bit of a confused one, actually, because (...) in June, sixth year at school I was out at [mental handicap community], the farm, so I worked out there for a week (...) I've been to children's mental handicap hospital as well, and I had a look round there.

He went on to describe what he saw at both these places, so his mental handicap picture seemed to be one based on recently observed reality, rather than one that had the same intangible quality of typicality that many of the other students' pictures had. The characteristic features he mentioned included "a playroom", "big brightly coloured toys", a setting which was "all split up ... a lot like homes", "a lot of decoration", "a lotta things to keep them happy", and "play trikes". So Malcolm, too, saw his chosen field of nursing as being more relaxed, "more homey", less formal than general nursing, which appeared in his typical picture.

Julie, another mental handicap student, was the second not to offer a general nursing picture when asked for her typical picture. She saw patients sitting around in a sitting room, talking with nurses. In response to being asked what she would picture for general nursing, she gave a description that had much in common with the typical

picture of most of the other students: a big ward, patients in beds, busy, and smelling of antiseptic, disinfectant and bleach.

In this general picture, an interesting feature was that there were nurses rushing about with things in their hands which, as Julie put it, wouldn't make any sense to her at that moment, because she didn't know anything about them yet. She was the only student to articulate this feature of her picture, but she seemed to have put into words a notion that underlay other students' descriptions — the idea that there were mysteries in her picture, things that she "saw" in some vague sense, even though she didn't know what they were.

Picture of a Nurse

Many students incorporated elements within the descriptions of their nursing images that made it possible to build up a "picture of a nurse". Some students remembered images from their childhood and were able to differentiate between these and their more recent images. Some seemed to be describing nurses they had known, while others were unable to say where they had acquired their pictures.

Students described what the nurses in their pictures looked like, what they were doing, their qualities or characteristics, and/or how they acted or what attitude they displayed.

Tina described two pictures of nurses, one from her early childhood and one from more recent times. Both pictures seemed to be rooted in hospital experiences.

- T - I didn't really remember much when I was little, because I was always getting put to sleep all the time, and I couldn't remember much. All I could remember was like sitting in a room with my mum and she used to tell me stories, and feed me, and I used to play, and that's all I can remember. I can't remember being sick or ill or anything. (...) (The nurse) was nice to you and looked after you and helped you all the time ...

She went on to describe her more recent picture.

- T - The nurse was always there when you wanted her (...) they were all young nurses in my ward, even the sister and they were all really nice to you (...) you suffered an awful lot of pain, but even though there was pain, I did really enjoy my stay in hospital, I mean I thought it was really nice, cause they were all willing to sit down and chat to you (...) they just told me everything he'd done, what was going to happen and everything, I was always informed really well. (...) I watched them an awful lot after I was a wee bit better (...) they never like lost their temper, even though you were asking them stupid questions that you knew they didn't know anything about. (...) And even when they had to give you injections and everything, they were chatting all the time trying to get your mind off it. They were really nice. (...) I had a drip in my hand (...) it was OK for the first few days, and then it started getting sore (...) but it was the doctors that came round and injected into that, so, like, nurses were always nice to you, because it was the doctors that were giving you the injections. But when the nurses gave you injections, I didn't like that very much, but, I mean, I didn't

really hold it against them, because I knew it was going to make me better in the long run.

One interesting feature of this account was Tina's apparent attribution of motives or intentions to the actors. She implied that she had held it against the doctors when they hurt her, whereas although the nurses also hurt her, she said she didn't hold it against them, because they were doing it to make her better. She doesn't seem to have allowed the same justification for the doctors' injections.

The overall picture of a nurse from Tina's account is of a female who is nice, who is there when you need her, who sometimes hurts you for your own good, and who chats and explains to you the things you don't understand, never losing her temper however stupid your questions might be. Thus she seems to be characterized by the attributes of her behaviour and motivation, rather than, for example, by any physical attributes, apart from being female and perhaps young.

The childhood elements of Rachel's picture of a nurse came into the conversation during a discussion of her unsuccessful application for nurse training two years earlier.

R - ... I lived beside the hospital in [city], and I kept seeing these ambulances come by, and it just sort of accumulated that I had to go back, so I just reapplied. But I hadn't intended comin' back after the first time.

AK - What was it about nursing that attracted you?

R - Don't know ... I suppose a lot of it probably was the image, specially when I was younger, the image of a nurse, a nurse is good and this sort of thing, and uniform. (...) When I was at school (...) I used to go to the nurse maybe once or twice a year, and they were all these great big fat women, you know, huge, so I mean, they were all really huge. [both laugh] (...) They were always smilin', they're always quite helpful and kind and that sort of thing, but, ... I suppose, like, seeing *Angels* and that, you think, "Aw, they're always slim," they were different, but, um, I don't know ...

AK - At the time you were applying for the first time, can you remember what your picture, what your image of nursing was at that time?

R - Um ... someone who looked after, ... aye, just looked after, it was, you were sort of separate, you just looked after the people ... oh, I don't know, I don't know if I ever actually thought about it. I can't remember actually thinkin' about what does a nurse actually do. I can remember ... I suppose thinkin' about the ... the sort of cardiograph things. (...) I can't really say.

Rachel seemed to have a more detailed idea of what she had pictured as a child than of what she had pictured at her entry to training. That is, as a child she had had a picture of a woman who was good, big and fat, smiling, helpful and kind, and wore a uniform. For her more recent picture, all she could say was that the nurse was slim and "different", and she seemed to want to identify what the nurse would be doing, but couldn't.

Zena's account of the nurse in her picture, which also harked back to her childhood, had a number of elements in common with the nurse in Rachel's picture.

Z - ... someone who's always smiling, I don't know why, but I always pictured a nurse as being quite fat (...) with big rosy red cheeks, and a big smile. (...) When I was like knee-high to a grasshopper, that's what I used to think.

Eileen's description included a picture of a nurse which seemed to have roots in a childhood view, though she didn't seem to recognize it as such at first. Her account is particularly interesting in view of the fact that she had had experience before training in two different types of wards during a health studies course.

E - She looks a bit strict, you know, she's a bit austere. (...) Just her face, she's not smilin'. [laughs] A weird picture! (...) She's already qualified. She's oldish, as well.

AK - And how is she dressed?

E - Maybe blue, with a white cap.

AK - Uh-huh, OK. (...) Do you know where this ward came from? Is it any place where you've worked, or seen?

E - No, no.

AK - Have you ever been a patient in hospital yourself?

E - Yeah. (...) I was nine or ten. (...) I think maybe that's probably where I got it, cause I didn't enjoy it at all, I mean, the sister wasn't nice, and ... I was young, and I wasn't happy. (...) That's probably where I got it. (...) It's not what I think, not at all!

Eileen seemed quite clear that her "weird" mental picture did exist, and she also seemed to have a long-lasting memory of particular details of her hospital experience as a child. The two seem to be closely related to each other. The odd feature is that her mental picture seemed not to have been influenced by her recent experience, which included working in an eye ward, which she described as a happy ward, and in a mental handicap ward, which she had "really enjoyed". It is interesting to contrast Eileen's picture of the strict, austere, unsmiling nurse with the fat, smiling pictures Rachel and Zena described.

The nurses that appeared in some of the students' pictures were described primarily in simple terms of appearance. In the case of Mary Ann, this may have been influenced by the way the question was put:

AK - What do the nurses look like to you? Can you picture them?

MA - They're in their white hats and their white uniforms an' a' ... looking quite good in them, really. (...) I like the uniform, uh-huh, I like the look of them. (...) That's what I've seen, you know, it'll probably look different when you go there, but that's sae far back that you canna really get away fae it, it's the kinda standard picture, that is.

AK - (...) Before you started seeing things in your training, if you were to try to picture a typical nurse that you would see in that picture, what would she look like? (...)

MA - Mmm...probably try to imagine myself in it.

Mary Ann thus seemed only able to describe her picture of a nurse as being a woman looking good in a white uniform and hat. Her response when prompted further, that is, that she would probably imagine herself in the picture if she tried to see what the nurse looked like, fits interestingly with her comments about the uniform when combined with something she said a bit further on in the interview:

AK - You mentioned on here [questionnaire] that you've watched *General Hospital* and *Angels*.

MA - Mm-hmm. That was when I was younger. (...) I always put my uniform on when I watched it and 'at. [both laugh] (...) Oh aye, I jus' put that on. I mean, that was when I was a lot younger.

It seemed that Mary Ann's identification with the uniform was a long-standing one. It is notable that she emphasized that wearing the uniform to watch nursing programmes on television was something from when she "was a lot younger," but that at the time of the interview, she was still saying, "I like the uniform ... I like the look of them."

Several other students' pictures of a nurse were primarily based on appearance as well. Wendy said that "As soon as the word nurse is mentioned, I see the uniform, for some strange reason." Ian said that before his pre-nursing course he would have pictured "a lady in a white uniform," and the difference now was that "the uniform would be green."

A number of the students described what the nurses would be doing. Angela said they would be "maybe administering medicines, or maybe attending to patients, getting them out of bed." Kathy saw them "dashing in and out with their trolleys and bedpans and things," but again added nothing further.

Malcolm described the nurses in his picture as "taking temperatures and checking if anybody needed painkillers," but also doing "just general sorta routine things, you know, about what you'd drunk and what you'd passed and stuff like that." Gail, too, described the nurses in terms of their activity:

G - ... fluffing up beds and helping patients, just sorta rushing round doing just normal things like bedpans or something like that. (...) although they do probably sit down and maybe get more of a chance to talk to patients (...) just making sure they're comfortable.

The nurses in Sarah's picture were described in slightly more varied but not very specific terms.

S - There would be a senior nurse sittin' at a desk, and there's junior nurses goin' back and forward to all the beds up and down (...) they're busy. (...) white uniforms, cause that's really the only uniforms apart from on telly that I've ever seen. And that's what I probably thought of them when I was little, cause you know, when you got the nurse's uniform when you were little, they were usually white.

AK - Did you have one when you were little?

S - Oh, yeah. Big red cross on the front, and the cap.

In response to being asked what kinds of things the nurses were busy doing, Sarah said they were "mostly just tuckin' in [the patients'] beds or just sittin' talkin' to them."

Donna's description of the nurses in her picture gave a different slant on them:

D - They're just like normal people that you would find in any other job, really. You know, you find funny ones, you find normal ones, you find ones you don't get on with at all, you find ones that you chum about with. (...) I was expecting a whole lot of nicey-nicey do-gooders, really. I didn't know what I was expecting. People that maybe just come out of college and were full of knowledge about all this medical ... medical people stuff was floating in a lot.

Donna added that in her initial picture there would have been "nurses all properly dressed, I mean, no hairs out of place and things like that." She thus seemed to recognize, by the time I interviewed her, that she had had a fairly idealized view of nurses, which had already been modified to some extent.

In Yvonne's picture, there seemed to be a clear distinction between the sister and other nursing staff. This included the description cited earlier of the "crabby sister". Thus, unlike most of the students, Yvonne seemed to have a picture of what the sister would act like, rather than what she would look like or what she was doing. As with her picture of the sister, Yvonne's view of the other trained staff had a fairly clear element of how they would behave, particularly towards students.

Y - They're better. I keep on thinkin', like the staff nurses, when the students come in, there's somebody that like shows you round and that, and then the sister assesses you or something, but I just felt like maybe the actual qualified staff would be more able to talk to you and have a more relationship with them than you and the sister of the ward.

So the "actual qualified staff" and the sister in her picture seem to have little in common with each other, either in role or temperament.

These students' pictures of nurses were thus quite varied in a number of respects, though they did have elements in common. In general, those who had a physical picture saw the nurses in uniform, but other characteristics varied. The uniform was perhaps the most prominent feature overall. Those whose pictures included the nurses' activity tended to view that activity either in non-specific terms or in terms of fairly trivial well-known tasks, such as taking temperatures, making beds, and dealing with bedpans (though none indicated just what it was that was being done with the

bedpans). Those who saw something about the nurses' personality or behaviour characteristics had pictures that ranged from smiling, jolly and helpful to dour, crabby and unsympathetic.

THE GOOD NURSE

Most students offered something in their interviews that could be classified as their picture of "the good nurse." Some elements of these pictures were indicated by direct description, others by implication.

In the first interview, Pat said that nursing was caring and in part this entailed "making sure they (patients) are as happy as possible." Nurses do this, she said

- P - by being cheery in their work, being happy themselves ... talking to them, listening to any problems they have, and if it's possible, trying to help them, or getting somebody who maybe can help them.

Further, the nurse should be "somebody who leaves their own problems outside the door." With regard to a patient's problems, she should be

- P - very sympathetic to that patient, but when she goes on to the next one, she shouldn't really take that patient's problems with her.

She suggested that the nurse accepts "the mucky side" of her work, although she "maybe doesn't like it." There seems to be an implication that this is the way the nurse *should* react; in other words, the good nurse would react that way. Pat also said, "I suppose another thing about the good nurse is the ability to take responsibility."

The theme of "the good nurse" was thus identified in the earliest interview, and the characteristic features turned out to be fairly typical of the images of many other students. The theme was pursued in the analysis of subsequent interviews, whether it came into the discussion explicitly or implicitly. Much of what fitted into the theme, students offered in response to prompts for information about their picture of "the nurse", not specifically "the good nurse". That is, when asked how they pictured nurses acting or reacting, they offered views of how the nurse *should* act or react. This ideal was discernibly different from the "picture of a nurse" because of the implied value judgment. Two strands that became obvious in the good nurse theme and were foreshadowed in Pat's interview involved notions of the personal qualities the nurse should have and notions of how the nurse should act.

Lorna had a picture of the qualities that made a person right for nursing. These included being understanding and patient, having a sense of humour, and being adaptable. In adapting to different ward situations and putting up with different kinds of people, this person should be able to put her own feelings behind her. She doesn't

show embarrassment, even when she feels embarrassed. She needs to be able to sit down and listen to people's problems.

Thus Lorna's account reinforced several features of the good nurse identified in Pat's picture. Pat's good nurse was sympathetic, Lorna's was understanding and patient; Pat's was able to leave her own problems outside work and could remain detached from patients' problems, Lorna's could put her own feelings behind her or cover them up; Pat's was able to talk with patients, both were able to listen; Pat's tolerated mucky jobs, Lorna's was adaptable to various situations regarding wards and people. Lorna did not mention Pat's good nurse's ability to take responsibility nor her cheerfulness, but she specified a sense of humour.

Analysis of the other interviews in the first set continued to reinforce many of these same good nurse features, while occasionally others appeared. These will now be considered. Because the two strands "personal qualities" and "ways of behaving" tended to be intermingled in students' accounts, they are both considered wherever they arise.

Cheerfulness

Cheerfulness made occasional reappearances as a feature of the persona of the good nurse. According to Becky, the nurse should have "a pleasurable manner with a nice smile,' because

B - if you were a patient, and you saw a nice friendly, smiling nurse, I think again you would be able to tell her anything you want to, but if you saw a nurse with a face like thunder or looking really miserable, it might make you feel miserable too.

Mary Ann offered a particularly descriptive account of the need for the good nurse to be cheerful.

MA - Well, as far as gettin' on wi' folk is, you gotta meet all sorts, probably folk that you wouldn't actually choose as somebody to get on wi', but you canna just start 'n speak to them 'n grump wi' them, or if you're comin' in an' you've a bad day, take it out on your patients. It doesna cost you anythin' to say, well, it's a nice day, how'ya feelin', or 'at, an' seem interested in them. Be as cheerful and chatty as you can, though some days you'll not feel like it, but just try an' get on wi' folk, make 'em feel as though you are interested in them, an' nae just nursin' them.

Her view of the nurse's cheerfulness is neatly interwoven with her view of the need to show an interest in people, which links with the next feature of the good nurse.

Understanding and Communication

“Understanding” appeared under the guise of a number of similar terms, including “empathy” and “sympathy”. While it is recognized that there are real differences in the meanings of such terms, no difference has been attributed to them here, on the grounds that it seemed unlikely that the students were using them with such precise comprehension and/or intention. Communication skills that facilitated understanding were also brought in and it became difficult to separate the two, that is, to separate the personal quality of understanding from the disposition to seek it through communication with patients.

Frances mentioned that a good nurse should be able to empathize, by which she meant, “Put yourself in their situation, as much as you can.” In addition, Frances indicated that the nurse should try to understand people, and should be alert to their needs and feelings.

In describing the good nurse’s qualities as perceived by the patient, Valerie said she should be “somebody you can talk to, somebody you can trust.” Talking to patients, she said, was very important. Angela, too, emphasized the importance of talking, and she and Zena both indicated the related importance of listening.

- A - Just to take the time to sit down and talk to them so that if you form like a trusting bond with the patient they may be more inclined to tell you any anxieties and things like that that they have.
- Z - Just looking after them, making them ... giving them somebody they can talk to or somebody who’s gonna give them a cup of tea or something, and somebody who’s got time to sit and listen to them.

Helen brought the related features of understanding and communication together in describing good nurse behaviour, saying, “The nurse’s sort of got to sit and listen to (the patient’s) problems, understand what he’s going through.” Gail suggested an additional aim of communication:

- G - Being able to sit down and maybe, if the patient’s not sure of what’s wrong with him, helping him to understand in more everyday language, rather than high-tech medical language.

Thus listening was a feature of several of the students’ pictures of the good nurse. Wendy particularly emphasized it:

- W - You’ve got to listen to the patient, I think ... Just treatin’ folk as individuals instead of just sort of gettin’ them all up an’ slap, bang, well that’s the breakfast, an’ time to toilet them (...) I think you just have to have a lot of sympathy an’ time, which you don’t have (...) mainly just listen to them and let them speak themselves, find out what their fears are.

So the good nurse was an individual who was able to communicate with patients, especially by listening, and who perhaps did this because she was understanding (had sympathy, was interested, etc), or who gained understanding by it. In these portions of the students' accounts, there was occasional evidence of a need for the good nurse to put her own feelings to one side when they would have conflicted with good nurse behaviour.

Involvement, Feelings and Selflessness

Several students brought up characteristics of the good nurse related to involvement with, or feelings of attachment to, patients. Another feature was the nurse's need to disregard her own feelings. Because facets of this were so interwoven that it was difficult to separate them, the three minor themes "involvement," "feelings," and "selflessness" are considered together in the following discussion.

When Pat said the nurse should be sympathetic to the patient but not take his problems on with her to the next patient, she seemed to imply a reserved sort of involvement which allowed the nurse to be (or appear to be) unaffected by it. In addition, the nurse ought to be able to suppress any problems of her own. Lorna indicated that the nurse should be able to put her own feelings behind her or cover them up.

Frances discussed the extent to which the nurse should become involved with patients.

- F - I think if I was nursing someone terminally ill (...) I think if I was really empathizing with them, I would be very upset, very, and it would maybe perhaps be too much involvement. You would have to draw back, a bit. (...) They become special, though they shouldn't. (...) I don't think you shouldn't become involved, because if you're not involved, then you stop caring. And that's what nursing should be about, about caring.

Frances began this part of the conversation speaking about how she imagined herself reacting, but soon began to imply what the good nurse's appropriate behaviour should be, "drawing back a bit" rather than becoming too involved, not feeling that some patients were special, yet becoming involved to some extent, as involvement is part of caring, which is central to nursing.

Becky was less certain that the nurse should become involved.

- B - I think she should care for patients but I don't think they always would. (...) They might not have the time, for one thing ... and, maybe her attitude is that she doesn't want to get involved with patients. (...) when they get put home, or if they died, or ... she might get emotionally involved. (...) I think that would be mostly a bad thing, 'cos it might affect her work, she'll only be thinking, well, is this going to happen to the rest of my patients, or she might just be generally feeling really low and maybe she won't be able to concentrate on what she's doing.

AK - (...) What does a nurse do if she's feeling low?

B - Well, she should try and just get on with her work, and find something to occupy her, and try and not let her feelings show too much.

There seems to be something paradoxical in this account. Becky indicates that the nurse should care about and for patients, but might not always do so for fear of getting involved, which she goes on to say is not a good thing. In other words, she seems to imply that caring, which is to be desired, would lead to involvement, which is not. The two sides of this paradox are represented in interviews with other students, rendering "involvement" a paradoxical theme.

Some students dealt with this paradox simply by indicating that a degree of involvement was desirable but should be limited. Valerie said the nurse should be like a friend to the patient, "as long as you don't get too involved." By "too involved", she meant "taking the patient's problems home with you." Not that she saw this as an easy matter:

V - I think it would be difficult, cause certain patients, you might get a bit too attached to them. (...) You sort of tend to go to them more rather than another patient, and give them all the attention.

Thus Valerie saw a practical reason why attachment to one patient could be detrimental to the nurse's work. Later she also alluded to the possibility of the nurse's having problems of her own.

V - Maybe family problems that you're maybe taking to work. (The nurse should) try not to let it affect your work. Or try and talk to somebody, cause talking usually helps.

So it seems that Valerie's good nurse is allowed to have problems, and can get help for them, but must not let them affect her work.

On Zena's questionnaire, she had indicated that a good nurse was "someone who'll care for people who won't get too involved with them." In her interview, she elaborated on this:

Z - It's that you're just looking after this person for so long and then they're going away and you're not going to see them again anyway. (When they leave) it shouldn't bother you (...)

AK - Can you imagine any times when you would be emotionally bothered by anything?

Z - Well, by a death, probably.

AK - (...) What should the nurse do in a situation like that?

Z - I think they try not to (get involved), but it's not easy, I don't suppose, not to.

Again a paradox seems evident, in that the nurse shouldn't be allowing herself to feel involved but perhaps cannot avoid it. Kathy's account reflected similar ideas:

AK - [From questionnaire] why do you need not to become too sympathetic and not too involved?

K - Well, not to be too involved, if the patient doesn't recover, he's going to die, then you've got to sort of detach yourself from it, because if you become too attached, then every patient that's gonna die, you're gonna wonder if it was your fault, or you're going to be emotional, and that would affect how you treat other patients. (...) You've got to be involved, because you've got to know about the patient's wants and how you can help them, but if you become too involved with one patient, and it's very obvious that you're too involved, then other patients might feel a bit put out at this, and you're not giving them the attention that they really need, I mean, you want to give equal attention ...

So Kathy saw some of the same factors other students have mentioned, such as the need not to favour some patients over others and the need not to let feelings interfere with one's ability to give care. In addition, she suggested the danger of feeling responsible for the patient's life or death. Presumably, in Kathy's view, if the nurse becomes excessively attached to a patient, she may feel she has let him down if she allows him to die. Again the paradox is evident in that the good nurse needs to become involved to do a good job, but through her involvement may become unable to do a good job.

Donna seemed to be aware of the nurse's difficult position in relation to this paradox, particularly for the beginner.

D - I think (...) emotionally the nurse is going to be in for an awful time, to start with. (...) I think I'll probably come around to my mum a few times, crying the tears.

AK - Mm-hmm. What do you think about that? Do you think that's something that's OK for the nurse to do (...)?

D - We-e-ll, I think to start with it's got to be acceptable, because you can't be normal if you don't show your feelings to start with, but I think as time goes on you sort of learn to control your feelings a bit more, but I hope I never get to the stage that I don't show any feelings at all.

AK - Uh-huh. So would you think then to be a good nurse ...

D - You have to show some feelings, oh yes. You got to. (...) I'm gonna try my hardest not to get involved, but I mean, you just can't, you'd have to get involved, when you're doing some caring and that, and so it's just the fear of being hurt (...) I'm just scared of somebody dying on you, and you're gonna get hurt.

The notion of an ideal balance is apparent, but acknowledged to be problematic. Eileen also articulated the paradox.

E - I think a lot of nurses have sort of tried too hard not to attach themselves, and then the patient thinks they're being cold to them, you know, they just don't really care, so you've got to sort of get ... I don't know, if you get involved, then it's just, you can't win, it's a no-win situation! [laughs ruefully]

In this regard, Muff has suggested that nurses are trained to allow the balance to be struck in favour of patients' needs at the expense of their own. She says "Nightingalism", meaning selflessness in nursing parlance, involves undervaluing oneself and over-valuing others (1988:204). Students such as Eileen and Donna seemed to be trying to work through this aspect of the image they had of nursing, without (at this point) being able to resolve it.

Several of the above selections show that the students often envisaged the nurse's likely attachment or involvement as related to death situations. Gail indicated this, and again referred to the paradox:

G - It could sorta end up really getting you down, if you had a patient that died, and you thought, oh no, and you go home at night and you're just so depressed, it would just get you down. I mean, it's OK for maybe just in the ward (...) not be so totally depressed once you get home (...) You have to get attached so that you're not hostile towards them (...) you know, brisk, and not make them feel so comfortable.

Wendy also alluded to death as an especially difficult situation, and imagined that the nurse shouldn't take feelings about such events away from work with her.

W - I think it would be very depressing, sad work. (...) I think it would be quite difficult leavin' your work and just cuttin' off, but I think that's what you'd have to do, really. (...) I think you'd really have to be hard about it when you finish your job, and just say, "right, that's it." (...) I think I'd be really quite choked up about it. I hope I'm not, but, you know, that's what I think I would feel like.

When asked about difficult situations, Natalie, too, immediately referred to a death situation. She seemed to allow for the nurse's being upset but not reacting until later, and it seemed to be acceptable to take her feelings home with her.

N - I suppose you hope if things have to be done it wouldn't be enough to stop you doing what has to be done. (...) I'm sure that I will have a good blubber, but I mean [laughing] you can't go blubber whilst they're dying, can you? (...) I'm sure you probably get more and more upset as you go on, really, but can control it better.

Natalie's view is interesting in that she does not see the nurse hardening over time, rather the reverse, but she sees her becoming more skilled at coping with her feelings.

Carol got onto the subject of the nurse's feelings of attachment while discussing death, which she said was the worst of the unpleasant aspects of nursing. Like Frances, she thought the nurse should get involved, and like Donna, she thought the nurse would become able to be more detached as she became more experienced.

C - (When someone dies) she'd probably go home and have a good cry. [laughs] (...) It's a job you canna hide your feelin's in. I've spoken to a few nurses, an' they've all said that although they try nae to get attached to the patients, they always do. But as you get on, you dinna get so attached, but you're still attached to them.

Yvonne, too, came to the topic of attachment via a discussion about death. Her account seems to reflect the inevitability of the nurse's involvement, the need for it, and the need to deal with the paradoxical aspects of it by maintaining some sort of balance.

Y - I think when you're working with somebody, you obviously have to have contact with them, and you do get to know them better. Some people say, oh don't really get close to them, in case the death does happen, but, I mean, I've spoken to this nurse, and she says you just can't do that, you do get to know them better, you know? But like, you're upset and that, but you just have to go on, I think. You know? (...) Maybe some people just wouldn't like to get so close or whatever. Maybe, see I don't really know, but maybe you're not meant to. (...) I think maybe you should like level it out, maybe not to get really really involved, but I mean, you can't not be involved, because they'll just think you don't care about them, you see. (...) So you have to balance it, I think.

Thus it seemed that involvement was especially likely to occur, in these students' images, in cases related to death. There was a range of views as to whether feelings of attachment were appropriate, and how the nurse should respond to such feelings. Many students indicated that the good nurse struck a balance, caring enough to benefit nurse-patient relationships but not enough to be hindered or hurt by the involvement. The paradoxes this issue entailed were evident and were articulated by some of the students, who recognized the no-win situation the nurse was in. Many expressed uncertainty as to how they would cope with this challenge themselves.

Dedication

The elements of this sub-theme included characteristics such as patience, a willingness to work hard and stay late if necessary, conscientiousness, and a willingness to do all this even for people the nurse doesn't like. (She is non-judgmental.) A few students actually used the words "dedicated" or "dedication," and some described the nurse's willingness to put herself out for patients.

The following quotes illustrate the elements of this sub-theme:

Patience:

I think patience is most important (...) You've gotta be patient, cause you're bound to meet different kinds of patients. (Lorna)

... if you were a patient in hospital and the nurse had a lot of patience, I think you would get her confidence and you would be able to tell her easier what was wrong, but if she didn't have a lot of patience and she couldn't be bothered with you, then you would just keep everything to yourself and you would be frightened to speak out and tell her what was wrong. (Becky)

Willingness to work hard:

A good nurse ought to be able to stay at the end of a shift and do a bit more if necessary. (Frances)

In nursin', I mean, if you're wantin' to mak a good nurse, you have to be willin' to work hard. (Carol)

Conscientiousness:

(The good nurse) has to be conscientious (...) if it's like concerned with taking samples and things, you've not to have them lying about, you've to make sure that they get to the lab immediately (...) or that medicines to be administered are given on time. (Angela)

(A good nurse) takes her job very seriously (...) and conscientiously ... (Carol)

Non-judgmental approach:

Obviously there's going to be some (patients) you're going to have a better understanding with. (...) If she doesn't like someone (...) she should try her very best not to show that she doesn't like them, but to do the best she can for them, to be as nice as she can. (Frances)

You gotta meet all sorts, probably folk that you wouldn't actually choose as somebody to get on wi', but you canna just start 'n speak to them 'n grump wi' them (you have to) gie them the benefit of the doubt an' nae sorta judge them. (Mary Ann)

Dedication:

(A good nurse) is someone who is dedicated to caring for people. (Angela)

(A good nurse) wouldn't mind doing anything to help the patient, as long as the patient was comfortable, they don't mind putting themselves out. (Helen)

The features of this sub-theme seem to fit well with those of the earlier-mentioned theme of selflessness. In her dedicated willingness to work hard and remain non-judgmental, doing conscientiously whatever the patient needs, the good nurse puts aside any negative feelings she may have, just as she may have to disregard her own needs and feelings when it comes to the emotional cost of getting involved.

Loyalty and Dependability

A few students mentioned characteristics of the trust invested in the nurse by patients. This might involve her acknowledging the patient's individuality, respecting confidentiality, or protecting the patient's dignity.

Frances mentioned the importance of "the relationship you would build up with a patient," saying, "You want to try and make everyone feel accepted, and nobody should be rejected." She also referred to the nurse's "allowing old and sick people to retain their dignity," for example by "not talking to old people like children."

Wendy reported having acquired many of her ideas about a good nurse through her earlier experience of having started training and having resigned, severely disappointed at what she found in the wards. What she had seen, she said, was what a good nurse should not be.

W - I felt really let down thinking that that's the way staff were, a lot of staff were (...) (I was) just disappointed that it wasn't as caring as I thought it might be (...) just treatin' folk as individuals instead of just sort of gettin' them all up an' slap, bang, well that's the breakfast, an' time to toilet them.

Wendy seems to be describing a disregard for the patients' dignity, along with a failure to acknowledge their individuality, as being the reverse of what she would expect of the good nurse.

Yvonne had written on her questionnaire, "A good nurse needs to be strict when needed, in a nice voice." She explained this further in her interview:

Y - If somebody's going mad, (...) shoutin' and whatever, you have to tell them to quiet down or, I mean, I [don't like] this view of somebody just shoutin' to them or something, and them feeling bad and unwanted. I mean, you've to tell them, but still in a lovin' kinda tone, so they can respect you and that.

Thus she indicated a need to protect the patient's self-esteem, thereby also maintaining the patient's esteem for the nurse.

Sarah said the good nurse should be loyal "in the sense that if they're tellin' you something, you don't go and say to someone else." This related to a lively description she gave entailing an analogy between the nurse's role and the role fulfilled for a child by his teddy bear.

The dedication sub-theme thus comprised a mixture of qualities that resulted in the patient's being able to depend on the nurse, whether it be to respect confidences, to maintain a feeling of being cared for, or to protect individuality and self-esteem.

Person and Personality

The final good-nurse sub-theme consisted of features which might be categorized as qualities of the person and her personality. A number of the students' views of the good nurse seemed to entail characteristics beyond those that could be learned or acquired.

Frances suggested that the good nurse had outside interests in life that contributed to the make-up of herself as a person.

F - I think if all nurses were just nurses, and they didn't have families and they didn't have hobbies and things like that, they were just nurses, they'd be very boring and they wouldn't be able to do much for their patients.

So in Frances's view, the nurse needs to bring something from outside into her nursing.

Donna described the other face of the inside-outside issue, that is, how being a nurse should affect the nurse outside of her work. Her account displayed ambivalence about this. She said at one point that nurses were "normal, just like normal people that you find in any job," but later said that nurses should "act a certain way," because certain types of behaviour "just wouldn't fit the image." She went on to say that she didn't think it was right that nurses "should have to act a certain way, but it's true."

Other personality characteristics described by students included: an ability to cope with all situations (Angela); a lively personality (Zena); kindness (Donna); a sense of humour (Lorna); common sense and a smart, tidy, pleasant, approachable appearance (Natalie). And according to Carol, "A good nurse (is) quite happy at her work."

One feature of the students' accounts of the good nurse was the near-absence of any mention of intelligence. Two students who were graduates actually indicated that being knowledgeable might be a problem. Natalie said she assumed she would need to take on an unquestioning attitude and do what she was told. Kathy was uncertain about how she would be accepted as a graduate, not knowing whether she would be expected to act as if she weren't too bright (i.e. should cover up any knowledge she might have) and just do as she was told, or whether she would be expected to know a lot, a thought which seemed to worry her equally, given that nursing was a new experience for her.

Thus it seemed that the general view of these students was that intelligence was not a hallmark of the good nurse, and some doubted that an appearance of intelligence would even be acceptable.

Eileen and Yvonne seemed to believe that the good nurse was born. Eileen said, "I think you've got to have it in you to do it (...), if you don't have nursin' in you, you won't be able to do it." Yvonne said:

Y - I couldn't see anybody that didna like to come in and work in it and that. (...)
There's just people that's fixed out for nurses, you know ...

Thus both Eileen and Yvonne seemed to think that being a good nurse depends on inherent qualities in an individual's personality make-up.

Sarah offered a different view of the origins of good nurse qualities.

S - It's very rare that you get someone that is the ideal person for a nurse, that works hard, 's efficient, and listens well, and things like that. There's not really anyone that comes into that category altogether, so you have to sorta be changed a bit.

So in Sarah's view, the ability to be a good nurse does not depend on innate qualities, but can be acquired.

Thus the good nurse of the students' initial images was probably cheerful and was an effective and understanding communicator. There was uncertainty as to how involved with her patients she should be, but it was seen as virtually impossible for her *not* to be involved in order to be a *good* nurse, and the patients' needs must be put before her own. For some students, this conflict was imagined to be difficult. The good nurse was pictured as being dedicated to her work, which she carried out conscientiously, with patience and tolerance. She built up a relationship of trust with patients, who knew they could depend on her. She was apparently not necessarily intelligent, but she had the right type of personality, whether she was born with it or developed it.

STUDENTS' IMAGES OF WHAT NURSING ENTAILS

This theme revolved around what the students imagined the work of a nurse to entail. Their views of the nature of the work are discussed briefly, and then three sub-themes which assumed a high profile in the students' images are singled out for discussion. Thus the discussion in this section covers the students' initial images of:

- the nature of nursing work;
- the satisfactions and rewards: "the good";
- the difficulties and unpleasantness: "the bad"; and
- getting attached/involved.

Once again there is a certain amount of overlap between the sub-themes, and a degree of reiteration is unavoidable, though this has been limited to that which is necessary for clarity of explanation.

The Nature of the Work

Students described nursing as entailing physical work. They mentioned specific tasks such as making beds, washing and tidying, giving baths, taking TPRs (an abbreviation used by several students), giving out medicines, giving injections, doing dressings, and feeding people.

A few students referred to the "mucky" side of the nurse's work, about which Pat said, "at times it can be thoroughly disgusting." Natalie contrasted such tasks with what one might (mistakenly, in her view) think nurses did.

- N - I think (nurses) do dog's body work. (...) I figure you just do a lot of clearing up, and making anyone comfortable. I don't think you do particularly any

fantastic life-saving things. (...) I think most of the time you're just giving people what they need, and cleaning up.

Eileen described the work as "doin' things that people can't do for themselves."

Most students mentioned non-physical aspects of the work they pictured a nurse doing, often referring to it as "emotional" or "mental".

Elements related to communication had a high profile. Talking and listening were mentioned as important by many students. Becky indicated that listening also involved acting interested, that the nurse was company for patients and spent time sitting and chatting with them. Valerie added that talking might involve family, that it might be about problems the patient had, and that in geriatrics, the nurse might be listening to the patient's whole life story. Sarah thought that although listening to patients was part of what a nurse does, there was inadequate time for it, partly because of understaffing. Zena also implied this and said that part of what a nurse has to do is to "act as if she has got enough time to sit and listen."

Carol saw communicating in the context of its purpose.

C - I think a lot o' helpin' people, makkin' people feel better, is speakin' to them, 'n just chattin' away an' sharin' a joke 'n just passin' the time o' day wi' them.

"Making patients happy" was referred to by both Pat and Lorna as part of the nurse's work.

Closely related to the emotional or mental work of the nurse was the sub-theme "working with people". Angela and Wendy both mentioned that nursing meant dealing with individuals, and Angela added the idea of helping them toward recovery, which involved forming a relationship with the patient. Zena indicated that this relationship might develop into a friendship, especially in long-stay wards.

Dealing with individual people, Kathy said, meant that the nurse takes into account their needs according to their age, their home routine, their social background, and their preferences. In addition, some of those individuals would not be recovering.

K - I think it's a thing you've got to accept that a lot of people you'll see aren't gonna get better. And there'll be a lot of chronic conditions that you see and you're there to ensure that the patient is kept as comfortable as possible and has the best quality of life that's available.

Natalie alluded to working with other staff, indicating that as a nurse one would "feel more of a team, more camaraderie amongst the people" than in many other types of work. However, in most students' accounts, the people that seemed to be important for getting along with were the patients and families. Yvonne said:

Y - The people who come in, they are in for the purpose, to get help and that, you see, so, I just thought, well, y'ken, we're just there for them.

Many students stated or implied that nursing involved stress. Some elements that relate to this sub-theme are discussed as part of “the bad” of nursing later in this chapter. Those discussed here are ones that the students did not seem to see as necessarily difficult to face or hard to cope with, from their personal points of view, though other people (non-nurses) might find them too difficult to cope with.

Valerie had said on her questionnaire that a good nurse “should be level-headed and be able to cope under stressful situations.” She was asked in her first interview to elaborate on what the stressful situations would be.

- V - Being understaffed, and having a busy ward. Like in a geriatric ward, everybody's got to be toileted, everybody's got to be dressed, and maybe half the patients have to be fed, and you've maybe just got four members of staff on.

The nurse would have to cope with such pressures even though she might have “family problems that you're maybe taking to work,” in which case she had to “try not to let it affect your work.”

Understaffing as a cause of stress was also mentioned by Sarah.

- S - I don't think you have time to sit down two hours in a day and listen to someone. (...) I don't think there's enough time allocated in hospitals to listen to patients. But then that is purely because you're understaffed and you're doin' more than you should do.

Mary Ann said the nurse was

- MA - ...on the go all the time, doin' things wi' folk, if you've a busy day or 'at, it would be quite physical and demandin', 'n you have to listen to problem after problem.

Both she and Sarah seemed to picture a dual pressure in nursing, the physical pressure of work that had to be done, and the pressure to deal adequately with the psychosocial needs of patients. This fits with an aspect of nursing's public image described by Hunt.

(A) very strong and consistent image is that nurses are overworked, and if not overworked then they are always working hard. (...) Associated with the overwork is the image of nurses being ‘too busy’ — too busy to spent [*sic*] time with patients, to talk with them, explain to them, teach them... (1984:54)

Sarah also mentioned shift work as a cause of stress and as detrimental to the nurse's ability to communicate effectively.

- S - If you're working a twelve-hour night shift, you're not really feeling like talkin' to someone (...) because you probably don't sleep that well during the day (...) and you're doin' all your work at night, and you're also listenin' to some patient goin' on about somethin', and I don't think you're fully with them, like your heart's not there, maybe your body is, but you're elsewhere.

She seemed to believe it would inevitably be difficult to sleep during the day, for night duty.

Natalie hinted at an element of stress related to what she called the “discipline” involved in nursing. She also brought in the idea of “outside” (and, by implication, “inside”) nursing.

N - I think it's quite disciplined, you feel like you have to jump when people say “jump”. (...) That's a lot different from working outside, cause (...) outside you use your initiative more.

By “outside”, she meant, for example, working in industry. She seemed to see the discipline in nursing as necessitating the suppression of one's initiative.

Frances believed that the need to treat people as individuals produced stress. She thought such stress would not be limited to working hours: “you're not going to be able to switch off at the end of your shift.”

Wendy spoke about the stress of working with people who were going through difficult experiences. Her conclusion was slightly different from Frances's, though.

W - I think it would be quite difficult leavin' your work and just cuttin' off, but I think that's what you'd have to do. (...) I think you'd really have to be hard about it when you finish your job, and just say, “Right, that's it.”

So whereas Frances thought nursing was impossible to switch off, Wendy thought the nurse could not afford *not* to switch off.

Thus aspects of students' images of what nursing entails included physical work, emotional work, working with people, and various types of stress. The physical work included a variety of well-known tasks. The mental or emotional work related primarily to making patients happy, talking to them, and listening to their problems. The people that the nurse had to work with and get along with included all sorts of individuals, both patients and staff. The stress might relate to being busy and understaffed, shift work, a need to submit to discipline, and a need to switch off one's concern for patients, or an inability to switch it off, at the end of a shift.

Satisfactions and Rewards: “The Good”

All the students mentioned something about what they thought was good about nursing. These elements were variously identified as the rewards or satisfactions nursing would bring, what a person would get out of nursing, and what made it fulfilling. These make up the sub-theme “the good”. This seemed an important aspect of nursing as viewed by the students, and their accounts often implied their own presence in the

picture, though the accounts were usually expressed in the third person or using "you" in its commonly (ab)used sense of the impersonal "one". Those aspects that seemed to be most important to students were seeing improvement, making things better, personal satisfaction, getting thanks, and meeting people. Less frequently appearing elements included being trusted, variety, learning, and being challenged. These will not be specifically discussed.

SEEING IMPROVEMENT

"Improvement" in the students' accounts related primarily, though not exclusively, to recovery or rehabilitation. The idea of seeing people get better and/or go home well was expressed by all the students in one form or another. As Angela described it:

- A - If you've got a critically ill patient comes in that doesn't look like there's a lot of hope for them, (...) you finally see them leaving the ward in a better state than what they came in, I think that would give you a great sense of satisfaction.

Donna described improvement in relation to children's nursing:

- D - If they come in and they're really ill, and you see them get better, and then you see them go home with their mum and dad and play normally, then that's great.

Mary Ann's account related to mental nursing:

- MA - ...you can see someone maybe discharged from a psychiatric hospital that can maybe manage themselves in the community, somebody gettin' better...

Malcolm spoke of improvement in a mental handicap context:

- M - ...seein' somebody achieve somethin' that was, you know, just had to be achieved through effort, somethin' that wasn't a foregone conclusion, say like somebody learnin' how to feed themselves.

Pat suggested an additional feature for mental handicap nursing:

- P - In the field I'm hoping to go in for, seeing a patient happy, treating the ward as if it was their own home.

She seemed to believe it was possible to find satisfaction in seeing a different sort of improvement in a person for whom physical or intellectual change was not possible, perhaps an emotional or social improvement or success.

A common factor in such accounts was that the students seemed to picture the nurse's gaining satisfaction from the observing of improvement, irrespective of their own part in its achievement. They imagined it would be rewarding to "see someone get better," "see someone go home," or "see somebody achieve something," implying a passive, and perhaps selfless, appreciation of the good fortune of others. Wendy, who hoped to do midwifery, pictured the satisfaction of seeing a birth, which seemed to

share the same type of passive satisfaction. She said, "I think that would be lovely every day goin' and havin' lots of nice experiences." She described a birth as a satisfying event to observe, without indicating that it would be something the midwife would be participating in. She did seem to suspect that her view was a bit unrealistic, because she laughed and added, "...but maybe it won't be like that."

MAKING THINGS BETTER

Students also described satisfactions or rewards that would arise when the nurse was aware of having played a part in a patient's improvement. They often described *making* or *helping* a patient get better, as distinct from *seeing* a patient get better. Helen and Natalie described satisfaction of this type in their interviews.

- H - (The nurse) gets the satisfaction of, she's had a very ill patient and the patient gets better, obviously that's gonna boost her up, and just the fact that she's helping somebody to recover.
- N - I think you can see a result, somebody comes in, seeing when they get better (...) due to good nursing care (...) seeing the results of the work that you've done...

Carol envisaged satisfaction from making patients happy.

- C - I mean, even if you were just sittin' doon an' speak t'l a patient for half an 'oor and 'at patient was happier fin you leave them ...

Many students imagined that the satisfaction of the nurse's accomplishment did not always have to be related to patients who recovered or improved, but could be found in the care of patients who were long-term or terminally ill. Examples are found in Angela's and Becky's accounts.

- A - I think if you have a terminally ill patient that comes in in great pain and you can keep them comfortable and reduce their pain as much as possible so they're more comfortable, I think that would give you a sense of satisfaction to know that you've actually helped to relieve their pain.
- B - ...just making their stay in hospital as good as you can. And if you manage to do that and make them feel they're happy, then I think you'd be satisfied.

Thus students' initial images of nursing satisfaction or reward derived from being able to help people to get better, by aiding their physical recovery, by relieving pain or otherwise making them comfortable, or by making them happier.

PERSONAL SATISFACTION

A number of students indicated that they pictured a personal satisfaction in nursing which did not necessarily depend upon extrinsic evidence. Such satisfaction related to the nurse's own awareness of his/her efforts.

Valerie said, "It's satisfying to know that you're doing the best you can for them," and Carol spoke of the nurse's "kennin' that she's doin' her job properly." Tina referred to "knowing that you've done a worthwhile job."

Ian offered a version of personal satisfaction that related to himself as benefitting, as well as others.

- I - I think I could break it into two sides. It would be something that I get out of it myself, and it's something I saw that I did for someone else.

Natalie indicated that internal satisfaction was the type that was appropriate to nursing, if any was:

- N - I don't think you should expect, you know, to be trumpets blowing or anything particularly like that. I think you just feel it within yourself, really. (...) I don't think you should always expect satisfaction anyway, you know.

Thus satisfaction could exist in nursing through an awareness of doing one's best, doing a good job, knowing one had done something worthwhile or something to help, and/or a sense of achievement, and such types of satisfaction were personal.

GETTING THANKS

A few students indicated that they thought one of the satisfying aspects of nursing was receiving thanks. Valerie said she thought the nurse's pleasure or satisfaction in what she was doing would include "getting thanks from the patients and the family." Donna described it in relation to children's nursing.

- D - ...get somebody say thank you or somebody come up and give you a cuddle, then that's nice.

Wendy mentioned "the feedback that you'll get back," such as:

- W - ...the nice things patients say to you, like "Oh, thank you," or "You've made me that bit more comfortable," or just things like that, just gettin' appreciated in your work.

Eileen indicated on her questionnaire that a good nurse was "a caring, understanding person, who can cope with the good and the bad." When asked what she pictured "the good" to be, she said, "The good would be of like gettin' thanks from the

patients, and patients who are grateful.” Ian sounded almost apologetic when he mentioned the idea of getting thanks.

- I - Maybe get some — this is probably startin’ to sound corny — maybe get some thanks for it, just seein’ that it was appreciated maybe that you’re helping them along.

MEETING PEOPLE

For some students, having the opportunity to meet people appeared in their pictures as a satisfying aspect of nursing. Kathy described:

- K - ...meeting so many different types of folk in the wards, and patients and the staff, you’d make different relationships on different levels, but you’re always learning something about people and about yourself.

For Rachel, too, the variety of people was pictured as one of nursing’s satisfying aspects.

- R - Workin’ with a wide variety of different people. (...) I suppose that would be quite good, that’d be interestin’. Havin’ to work with the same people every day in an office, [laughs] that can get on your ... ach, I suppose I’ll be workin’ wi’ the same people quite often, but certainly when I’m trainin’ it’ll only be for thirteen weeks (...) I think that’ll be good.

In part, the appeal for Rachel seemed to be a feature of student nursing. She anticipated enjoying the variety conferred by the student’s transiency.

When Wendy was asked what ways she thought nurses gained satisfaction, she said:

- W - Hopefully, workin’ with nice staff. People goin’ in to meet other folk that enjoy their work as well. (...) Everybody’s happy. [laughs]

The students thus seemed to see working with and meeting people as part of nursing’s satisfaction because of the variety it conferred, via patients and/or work colleagues, and the pleasantness of developing happy relationships.

There was considerable consistency in the students’ images of the good, the satisfactions and rewards in nursing. In many ways, the students’ accounts of their images of the good in nursing resembled features reported by Hughes *et al.* In one study they reported, the most common reason given by students for wanting to do nursing was their desire to help others (1958:211). From another study, they reported that

...trite though it may sound, nurses like people and often from childhood have yearned to help the sick. Like other people, they find it

difficult to confess to altruistic love and they gave such answers as: "I know it sound silly. It is silly; but I like people." (...) ...love of people and particularly the urge to aid the helpless is firmly established as a pervasive motive for nursing and as the greatest satisfaction found there, once one has embraced the profession. (1958:214)

Difficulties and Unpleasantness: "The Bad"

Just as most of the students had ideas of what they pictured as the good features of nursing, so they also pictured the bad. This sub-theme comprises features they imagined as unpleasant or difficult to cope with. Its elements are discussed in conceptually related groups: death, suffering and giving bad news; other dreads; difficult people; and organization-related features. Coping with mucky jobs has already been discussed, and most students who mentioned such features denied seeing them as particularly bad in their own view, but thought they would be bad in most people's views. Those that did matter to them are included among "other dreads".

DEATH, SUFFERING AND GIVING BAD NEWS

Death and related factors made up the most commonly cited element of "the bad" as these students pictured nursing. They suggested the difficulty of the emotional care of dying patients, the pain of seeing them suffer, the shock of seeing a dead body, and/or the difficulty of dealing with relatives. In this context, students showed a particular tendency to place themselves in the picture in the first person.

Gail had said on her questionnaire, "Nursing is also the care of the dying and therefore nurses should be prepared for the bad as well as the good things in life." Carol was firm in offering a similar view.

- C - I think mainly death'd be the worst (...) definitely. I'm dreading', if my first patient that dies on me, I think that would be really horrible. I would say 'at would be the worst aspect of nursin'.

Yvonne gave a similarly unequivocal response regarding her image of the most difficult thing to face in nursing.

- Y - [no hesitation] I would say it was death. (...) Actually seein', you know ... well, I remember when my Granda died, it was just, the coffin was in the room, and he was there, but some people went to see it, but I mean, I was smaller then, so I mean, I never saw, and I think 'at's goin' to be one of the hardest things, anyway for me, just for the first time, seein'.

Though it was similarly about a first experience, Yvonne's view seemed to differ from Carol's in that it specifically related to seeing a dead person rather than having a patient die on her.

Natalie also viewed death as difficult to face, and she, too, was relatively inexperienced.

- N - I think it would be dying patients. I've not really come across death much. (...) I think you'd probably get more used to it, it's just a case of the unknown, I think you have to get used to it, but there's no accounting how people react, knowing how to feel, but it's all right offering cups of tea and sympathy, but that's not really useful.

She had said that her concern was more for the physical aspects than the emotional or psychological, but her further explanation seemed to contradict that, in that it was about having to deal with the survivors' need for support.

Ian spoke of the nurse's "frustrations if you can't do anything, if somebody's, you know, goin' to die." Frustration comes across in Rachel's account as well.

- R - It would be terrible if somebody died and they were terrified. You would try to reassure them ... I don't know ... like I think they would be goin' to a better place ... you can't give people, I don't know how to put it, I don't know ... I would like to try and make them realize that ... you know, you can't tell them that they're dyin', I don't know. If I thought they'd died at peace I would be, OK I'd probably be upset, but I would feel, oh well, that's better. If they died in an awful lot of pain and anguish and that, then you'd think, oh, I wish I'd been able to do somethin' more for them.

She seemed to see the idea of unrelieved suffering as more difficult to face than the actual death, and she imagined the frustration of wanting to reassure people about death when she wasn't permitted to let on to them that they were dying.

Lorna indicated another difficulty related to dealing with death.

- L - If somebody has just died or something, then it's going to be awful hard to just get back into the job without thinking of it. I don't really know.

Kathy identified the nurse's communication difficulties related to death situations.

- K - ...how to tell relatives someone's died, or having to tell the patient, or if he asks you a straight question, how do you answer him...

Helen and Donna pictured death in the context of paediatric nursing. Helen said, with a nervous laugh, "If a child actually dies, I don't know how I'm gonna cope with that, but I'll probably find out." Donna mentioned dealing with death and coping with the need for communication. Her account had features in common with Carol's and Yvonne's, though theirs had referred to adult nursing.

- D - I think the most difficult would have to be dying, somebody dying, especially if you get to know them, I think this must be really really difficult, in fact I'm really dreading it happening, I'm really dreading it. (...) That must be the worst thing. And maybe trying to help the mums or the relatives through it. You know, trying to help, but trying to sorta tell anyone. I don't know if the nurse tells them or if the doctors tell them or who does, but the nurse must have some part in it somewhere. So I don't think that'll be awful pleasant.

Sarah mentioned death as a negative feature in a rather different context. It would be "quite upsetting", she said,

S - when they die in the mental hospital when (...) they've been there since sixteen and then they live there till they're dead [old], and things like that, you feel sorry, cause even when they're alive (...) you always feel, well there's a chance, we can maybe get her to walk in the gardens and see some more things, you know, but when they're dead and they haven't managed that, you think, "Well, I've failed, I haven't got her outside or anythin'."

Thus it was not the death *per se* that she pictured as difficult to cope with, but the absence of what she saw as a fulfilled life by the time of death.

It seemed that for many students, especially those with no experience of it, death loomed large in their pictures of the bad in nursing, sometimes along with accompanying features of suffering and difficult communication. For the inexperienced students, it seemed that one characteristic of this element was its unknown-ness, and their own inability to know how they would cope with it when the occasion arose, as evidenced by their frequent use of comments such as, "I don't really know."

It was noticeable that although an effort was made to get students to speak of this topic as part of a impersonal or abstract picture of nursing, most discussed it as applying to themselves. A question such as "What do you imagine would be difficult for the nurse to face in her work?" was likely to elicit a death-related answer beginning with a phrase such as "The thing I'm dreading is...". Death thus seemed to be the bad element of greatest concern to them.

OTHER DREADS

Other features of nursing which students described themselves as dreading included both physical and social elements.

Lorna's dread of her first bed bath to a man was social in nature. She thought the reason for her anticipated feelings of embarrassment was that "it's a really closed society we've got" and this had affected the way she had been brought up. Thus she believed that the embarrassment she had been socialized to feel would conflict with an expectation that would be placed on her in nursing, namely that she not show embarrassment. Yvonne expressed a similar concern.

Y - I would say, it's nae a really bad one, but having somebody you really really know, and you were putten in their ward and having to look after them and that. (...) If it's somebody you know and they're younger and that, maybe...

AK - (...) What would be the worst things you might have to do for them?

Y - Bed bath! [laughs]

Carol and Wendy had dreads that were to do with the physical nature of certain aspects of nursing.

- C - Givin' people needles! [laughs] (...) I'm dreadin' that. Basically, the first time will be the worst. But no, I dinna fancy deein' that. I ken mysel' how it feels. (...) Fin I get a needle, I always sit an'... [grimaces], an' I ken mysel' that I'm scared, so, you ken that fa'ever you're geein' it t'l is probably scared an' a', an' you canna help but feel sorry for them! [laughs]
- W - Maybe things like a lumbar puncture, things like that would be, uuuagh!, I'd be feelin' for the patient more than anythin', you know, oh my god, but, just things like that, I don't really ... I'm not bothered about things like that at all. Maybe I will be when I get out there [laughs]. Maybe change my mind.

This seemed a case of protesting too much, or perhaps wishful thinking, that Wendy wasn't "bothered about things like that at all," given the first part of her response and her facial expressions, which seemed to indicate that she was indeed bothered. Her concern seemed to be like Carol's, in that it related to the patient's feelings.

Wendy had another serious concern, on her own behalf in this instance.

- W - I think I'm gonna find psychiatric quite distressing. (...) I think it's just cause it's so unknown to me, and I don't really know what to expect, I think that's mainly it. Until I'm there ... I might change my mind totally, I hope I do, anyway, cause, it's psychogeriatrics I'm goin' to this time, and I've met some of them, and I just felt sorry for them more than anything, I wasn't scared of them, that they were gonna lash out or anything...

She seemed to be implying that psychiatric patients would scare her, but was also quite clear that it was the unknown-ness of psychiatry that gave her the most concern.

DIFFICULT PEOPLE

In a few of the students pictures, difficult people made up one of the unpleasant aspects of nursing. These people included patients, staff (rarely), and unspecified others.

Lorna mentioned both staff and patients.

- L - You're bound to meet different kinds of patients, ones that'll hardly say a word and ones that'll moan, I've got a gran in hospital and she moans like nothin' [laughs], I dunno how the nurses put up with her (but) you've gotta put all those feelings behind you. Cause as soon as you start to notice these things, well, it makes their stay in hospital even worse. As if it's not bad enough being away from home, but having to get along with staff who won't talk to you or anything.

(She seemed to mean that patients might have to get along with staff who wouldn't talk to them, not that the staff might not speak to her.)

Frances had a more dramatic view of difficult people.

- F - If you're working in Casualty, you get these drunks, and people fighting, you have to cope with it, you can't shut the door and go away. It's your responsibility, you have to be there and ... take it. (...) Apart from the people you actually work with, some of them might not be too pleasant, but the patients, you can't answer back.

Valerie had mentioned on her questionnaire the "abuse (nurses) are likely to receive from patients and patients' families." She expanded on this in her interview.

- V - Well, patients are not really happy in the hospitals, they sort of tend to take it out on the nurse, maybe psychiatric patients or mentally handicapped patients, who tend to maybe curse and swear at you, and thump you, or whatever.

In Kathy's view, it was visitors that might be difficult to deal with.

- K - ...there's bound to be some, when you've got people visiting patients and you don't want them to see, to visit them...

ORGANIZATION-RELATED FEATURES

In this sub-theme were the elements that related to difficulties caused by the way the system was organized. One of these was the conflict between work loads and staffing levels.

Sarah mentioned another feature related to the system of staffing, saying, "I think what's bad for the patients is they're not seeing the same nurse all the time, which is obviously impossible." One of the frustrations in Sarah's view of nursing seemed to be the system's inability to provide a consistent person for a patient to relate to. She seemed to see the hospital environment as one which ideally should provide a surrogate family situation. Her frame of reference for this was primarily a long-term psychiatric setting.

Shift work was brought up as part of the bad. Gail described this feature of her picture:

- G - The likes of no weekends and working nights and the hours, none of the hours are sort of sociable, really, are they? Half past seven in the morning, but if that's what you want to do, that's what you want to do, it's no point in saying, I don't like getting up early. If you want to be a nurse you have to do things like that, you have to work around it. (...) If they can't see themselves fitting into a routine, there's no point in doing it.

Thus Gail implied that these hardships that existed in nursing were in effect a test of a person's motivation, and one had to be able and willing to endure them to pass the test.

Natalie also viewed the shift work as part of the bad.

- N - It seems very tiring that you do like one day late and one day early. (...) You disrupt your own rhythm. I've worked shifts before, we used to do like one week on late shift, one week on early, and you can adjust to that quite easily.

Natalie seemed to view the irregular shift system as an unnecessary strain on the nurse's body rhythm. She did not seem to agree with Gail's view that the person should have to adapt to the system, since she believed it was possible for the system to be adapted.

Natalie had further system-related concern about the bad.

N - There would seem to be a lot of things have to be just so. I realize that's how they do it, but (...) at school, you're encouraged to express your individuality, and you kind of get it depressed a bit here [laughing]. (...) I realized that before. And I think if you realize it, you can cope with it, you think, oh well, that's just the way it is. It's no good making a scene about it.

So despite her earlier view with regard to the shift system that things could be different, in this case she seemed to be resigned to "the way it is".

Some elements of the bad in the students' initial images of nursing were seen again in later interviews, although a variety of alterations took place, as discussed in Chapters 6 and 7.

Getting Involved

The idea of becoming involved with patients or relatives came up in many of the interviews. It has been mentioned in relation to the good nurse, and it was interwoven with students' pictures of what nursing work entailed, in particular with the working-with-people element. It was thus also interwoven with the good, since working with people accounted for some of the satisfaction in nursing, in the students' pictures. However, it was not a unanimous view of the students that getting involved was a good thing. One interesting feature of this theme was the presence of apparent conflicts and paradoxes between the ideas of different students, and sometimes within individual students' pictures.

Notions of consequences were expressed by some students in their accounts. For example, often a student did not simply offer an idea such as "It's a good thing for nurses to get attached to patients," but also offered a rationale for why it is a good thing.

Students' views of getting involved fell into three conceptual sub-themes: the inevitability of getting involved; implications for patients; and implications for the nurse, including the need to avoid (or not to avoid) getting involved.

As a nurse, "you can't avoid getting involved," Julie said. Many of the students related this getting involved to caring. Nursing, they said, involved caring. This caring led to the nurse's developing feelings for the patient, thereby getting involved. Lorna said:

- L - If you're working with somebody as close as what you are in nursing, I mean, they're ill, so they depend on you to bath them and that kind of thing, you're also going to have some feelings for the person (...) especially the sick kids, you're bound to get involved with them. I mean, it's just part of the job, I think.

Thus she seemed to view the ensuing feelings of involvement as an inevitable part of nursing that would result from the caring component of the nurse's work. Caring for people would lead to caring about them. Frances was quite clear about this.

- F - If you're not involved, then you stop caring. And that's what nursing should be about, about caring.

In addition to seeing the development of involvement as unavoidable, some students also indicated that it was useful, even necessary, to the care of patients.

Some implications for patients of the nurse's involvement, as described by students, were physically practical, while others related to less tangible aspects of relationships the nurse established with patients. Kathy suggested, "You've got to be involved, because you've got to know about the patient's wants and how you can help them."

Gail's and Yvonne's views had more to do with the features of the relationship itself.

- G - You have to get attached so that you're not hostile towards them, I mean, if you say, oh, I'm not going to get attached to him, you might end up being hostile towards them, you know, brisk, and not make them feel so comfortable.
- Y - You can't not be involved, because they'll just think you don't care about them, you see.

Tina and Angela described a positive result of getting involved.

- T - It's good in some ways because you want the patient to feel they can trust you and help them.
- A - They may tell you things like that that they wouldn't necessarily tell a doctor or anything like that, and it's good in that respect, I mean, you're taking a burden off their shoulders if they can tell someone else.

Both Tina and Angela went on to give the other side of the coin, which is discussed below.

It seemed that although students saw the working-with-people aspect of nursing as one of its attractive features, most of the advantages of getting involved were for the patient. The implications for the nurse were perhaps not so positive.

Students pictured difficulties for the nurse in getting involved. For some, this implied that involvement was to be avoided or controlled, while for others, it meant the nurse had to learn to cope with it. Material related to this has been discussed in relation

to the good nurse and will be mentioned as part of “becoming a nurse” and is therefore not considered in detail here.

According to Donna, the risk for the nurse was the danger of being hurt. She related this to herself and her worry about dealing with death, as mentioned earlier. “Emotionally the nurse is going to be in for an awful time, I think, to begin with,” she said. Angela similarly thought the nurse would be vulnerable to hurt if she got attached to a patient.

A - It's not so good like if the patient died in that if you were more attached to them it would hit you harder.

So taken together with her views quoted earlier, Angela saw two sides to the issue of involvement, but she also had a view of how those two sides were related.

A - (It has) its good and its bad. But if it helps the patient, it's worth the cost.

So the benefit to the patient took precedence over the cost to the nurse.

Tina, too, saw two sides to the issue. She offered reasons to counter her view described earlier.

T - If you get too attached to them, it'd just ruin your job, you've gotta like be neutral all the time. (...) If you're too attached to them, and they die, say, you'll grieve for days and days and you won't be able to think about the other patients, and you won't have enough time for them because you'll still be thinking about this one patient that something's happened to them or that.

Instead of concluding, as Angela did, that the benefits to a patient of the nurse's involvement outweighed other possible disadvantages, Tina saw the two sides as having equal weight, and figuratively cancelling each other out, though this was not entirely for her own protection but for the benefit of other patients.

There seemed to be obvious conflicts and paradoxes in students' views about involvement with patients, aspects of which have been discussed as part of “involvement, feelings and selflessness” in relation to the good nurse. There were conflicts between students' views of the benefits and inevitability of involvement, and their views of the need to avoid involvement. These were sometimes coupled with an expressed belief that “they” said nurses should not get involved, though who “they” were was not clear. It seemed as if this view was a sort of received wisdom that could be attributed to society in general, rather than being the advice of a tutor or any other specific person in a position of authority.

Paradoxes appeared within some individual students' accounts. Becky's account quoted earlier provides an illustration of this, moving from “the nurse should care” to “I don't think they always would” to “maybe she doesn't want to get involved” to “it's a bad thing to get involved.” She did not seem to see any lack of logic in the idea that the

nurse should care but not get involved. A similar lack of logic occurred in Gail's account, in relation to the need not to get attached, combined with the impossibility of the nurse's not getting attached.

It is also interesting to consider the accounts of those students who looked askance at the idea of involvement alongside their discussions of what appealed to them about nursing and what they imagined brought the nurse satisfaction. On the one hand, a student might say that working with people was what made her decide to do nursing rather than some other occupation, and might imagine deriving satisfaction from a patient's happiness, while on the other hand she might state that the nurse should avoid emotional attachment to patients. The pictures these students had of nursing seemed to place a difficult set of expectations on the nurse.

OCCUPATIONAL LABELS FOR NURSING

Becker and Cowper have described the significance of occupational titles and the implied attributes of an occupation.

Kinds of work tend to be named, to become well-defined occupations, and an important part of a person's work-based identity grows out of his relationship to his occupational title. The names carry a great deal of symbolic meaning, which tends to be incorporated into the identity. They specify an area of endeavor belonging to those bearing the name and locate this area in relation to similar kinds of activity in a broader field. They also imply a great deal about the characteristics of their bearers, and these meanings are often systematized into elaborate ideologies which itemize the qualities, interests, and capabilities of those identified. (1970:178-9)

In exploring what nursing meant to the students in the present study, discussing the terms they saw as appropriate occupational labels elicited features they did not think to express when asked directly to describe their mental pictures of nursing.

The data did not show that one particular descriptive label was favoured. In any case, as students did not ascribe the same meanings to labels, it was the probing of meanings rather than the choice of labels which proved enlightening. There was much agreement as to one label that did not fit nursing very well, and that was "job".

"Not Just a Job"

Students' views on the label "job" ranged from adamant rejection, to a view that nursing had some job characteristics, though that label was not sufficient on its own. A phrase frequently used to describe nursing was that it was "not just a job".

There was an apparent contradiction in students' use of the word "job". They often used it in the sense of work, as in the phrase "the only job you'd really be happy doing." Malcolm at one point said a job was something one couldn't get job satisfaction from. However, it was clear from the context in any given instance whether a student was identifying an occupational label or merely using the word in the general sense of work.

Frances was unequivocal in her view:

- F - It's definitely not a job. (...) A job is something that you can put away at the weekend and when you go at night.

Becky had a different reason for rejecting job as a label.

- B - A job's really something you go to to make money, but nursing should be something where you're enjoying it and be able to help and care for the patient.

For Becky, nursing could not be a job because of the elements of caring and dedication she saw in her picture, elements which did not exist in her pictures of jobs, examples of which were secretaries and checkout assistants, who instead worked for money.

Valerie, too, said that a job was something done just for the money, such as a shop assistant, but "you're going into nursing because you want to do it, you want to care for people, (it's) about being dedicated."

Tina offered further views on the difference between nursing and a job.

- T - I wouldn't say it was, well, not your whole life, but a large per cent of your life. (...) If you're just, like, you're typing, or you're a secretary, whatever, you're not really dealing, well not intimately, with people. You're not really getting right into them and helping them and everything.

Donna suggested that if a person were not dedicated to nursing, it would be hard to tolerate, and this was part of what made job an inappropriate label.

- D - I don't think anyone could stick nursing if they were just doing it for a job, really, because, I mean, the hours, for one thing, and if anybody in their right mind wanted just to come here just to get off the dole queues, they wouldn't stick the (...) amount of work you get (...) plus, you get all these nasty jobs to do (...) so I don't think anyone could stick the job if it was just, if they just came for a job. I think you've got to want to do it.

It seems characteristic of the dedication alluded to by many of the students that it is less akin to altruism than to the individual's motivation arising from enjoyment of the work. Caring and helping are mentioned, but the idea that comes through more strongly is that a person has to really want to do it in order to tolerate what nursing will entail. It seems an almost paradoxical picture of a person struggling to put up with the work because it's so awful, and only being able to put up with it because he/she wants to do it. Their accounts indicate that this would not happen in a job.

Rachel considered that job as a label “doesn’t describe it, it’s more than a job.” A job, she said, is “somethin’ you go to and you come away from it and you want to forget about it,” such as working in a factory. It’s “somethin’ that you don’t get an awful lot of satisfaction from.” On the other hand, she said, nursing has to be something you enjoy, and (laughing), “I don’t think it could ever be boring.”

Malcolm suggested that nursing, unlike a job, provides an opportunity for the individual to develop. A job represented unpleasant drudgery, as exemplified by his previous job in a fast food shop.

Carol’s example of “just a job” was working in a supermarket.

- C - Workin’ in a supermarket, you learn maist o’ the basics in say a week, couple o’ months, but for nursin’, you’re learnin’ a’ the time. An’ it’s a lotta written work, an’ there’s a lotta pressure an’ experience putten onto you once you become a nurse. (...) Fair enough, you could become a manager o’ a shop, but it’s nae the same. I used to work in a supermarket, an’ (...) it’s just a job, (...) something to do. (...) In a shop, well, in the shop we worked in, there was nae push to mak ye work hard. The less you did, the better, in fact, cause it was horrible to work there. But at least in nursin’, I mean, if you’re wantin’ to mak a good nurse, you have to be willin’ to work hard an’ get it.

Carol’s account indicates that nursing entails motivation, hard work and commitment, and therefore it cannot be just a job.

Eileen’s contrast with nursing was waitressing, which is just a job because, she said, “You’re just into house cleanin’ an’ ’at, an’ cashier, doin’ the work, you’re just a skivvy sorta thing.” She implies, as Malcolm did, that nursing is not skivvy work.

Wendy hinted that possibly there was something of a job about nursing, depending on the attitude of the individual. Some people might look on it as a job if they were, for example, just doing it to supplement their husbands’ incomes. She said, though, that in essence it differed from a job, which is

- W - something you just go to every day and put in your nine to five, and you don’t really enjoy it, and you moan while you’re at your work, (...) nothing that you’re really gonna fulfil yourself in, you’re just goin’ in to get the money.

Lorna and Yvonne both stated that nursing was a job, but not because it had the job characteristics other students identified. Lorna said:

- L - Well, it is a job, but you can’t go into nursing and say, oh, I’m just doing it as a job, or else you won’t last. (...) You need understanding, so I think you’re either that way inclined or you’re not.

Her admission that nursing is a job seemed merely an acknowledgement that it was a type of employment.

In Yvonne’s case, she included “job” as one of four acceptable labels for nursing, the others being “career”, “profession” and “calling”. She indicated that nursing could be any or all of these, though for herself, she “wouldna say it was a job.” She

suggested that occupations varied in their potential to be more than a job. One could go into banking, for instance, just for a job, or “if they really want to be a banker” it could be a career. On the other hand, working in a shop offered no potential other than as a job, “just something to take in money.”

Natalie and Mary Ann both suggested features of belonging that would apply to nursing but not to a job” Natalie referred to being outside, and the camaraderie of being on the inside as part of the team, indicating a sense of belonging that would be felt once one had joined the nursing ranks.

For Mary Ann, the belonging had to do with joining a group who were setting out to do nursing at the same time. This distinguished it from a job such as working in an office or a shop, where one started alone. For some students training as a route to qualification differentiated nursing from “just a job”, but for Mary Ann it was training as a source of membership that made the difference.

In Kathy’s view, nursing was not best labelled a job because it entailed a choice with long-term implications. With jobs, such as working in a shop or a hotel, “you can chop and change, you’re not tied down to it,” but with nursing, you commit yourself.

Ian wrote on his questionnaire, “My idea of nursing is that it is caring for other people, and a job.” In his interview, he indicated that, having spent a year unemployed when he first left school, the idea of nursing’s being a job was important to him, but it was not the factor of greatest importance.

- I - It’s something I’d be interested in and enjoy doin’, and also it’s a job. (...) A job can be something very simple, like, say in a laundry, (...) day in day out you’d be washing clothes or whatever, but nursin’ there’s such a variety, you can advance, (...) and you can specialize.

A job, he said, was something you can “work in, just walk into,” which was not true of nursing.

The student who was the most willing to call nursing a job was Oliver. It was his firm second choice of label. He was not able to suggest any specific features of nursing that made it a job, but he stated that he would choose that as a label over either “profession” or “calling”. His further explanation, meant to clarify his preference for “career” as a first choice, seemed to counter his choice of “job”.

- O - A job really is something that you have mainly to maintain yourself in as grand a style as possible. Now, student nursing isn’t going to do that.

Thus despite his adamant tone, his views seemed to be contradictory.

The students’ ideas about jobs enhanced the developing picture of their images of nursing. In general, nursing was seen as being not just a job, with examples of jobs being shop assistant, receptionist, factory worker and cleaner. Jobs had the following characteristics:

- You leave a job behind when you go home from work.
- A job is boring, and you get in a rut.
- A job involves doing skivvy work.
- People working in jobs moan about them.
- You just do a job as a way to make money.
- A job is simple; anybody can do it.
- A job is not fulfilling, does not bring job satisfaction.
- You can easily change jobs, as they don't require any special training or any particular commitment.

Nursing, according to the students, did not share those features, and it had features a job did not share. Putting together the features of nursing as being not just a job and the positive features of nursing as itself, the following characteristics were suggested by the students' accounts in discussing "job" as an occupational label:

- Nursing is work you don't leave behind when you go home.
- Nursing is interesting and varied.
- Nursing is important work; it involves helping people in an intimate caring role.
- Nursing is complex; not just anybody can do it; a person has to be dedicated and motivated; it has to be something the person will enjoy and really want to do or you couldn't tolerate it; you couldn't do it just to make money.
- Nursing entails responsibility.
- Nursing is fulfilling and brings job satisfaction.
- Nursing requires training; it entails joining a group similarly seeking qualification; you become part of the inside world of the hospital.
- Nursing offers opportunities for development.
- Going into nursing requires a positive choice and commitment; it becomes your life.

Obviously, not all students mentioned all these features, but together they form a believable composite picture. There is a possible point of conflict in the matter of skivvy work. Some tasks suggested by students as skivvy work in a job, such as cleaning and serving, might also fit other students' views of unpleasant tasks that are part of nursing which the dedicated nurse must be willing to put up with, or even enjoy. Perhaps at this point in their training, students could see such similar tasks as different because of differences they perceived in the reasons for doing them. That is, cleaning the floor in a supermarket or the tables in a fast food shop might not appear as

worthwhile or admirable as cleaning up after a patient who was sick or incontinent (though it might well, in fact, be less distasteful!).

Profession

Another popular response among the students was that nursing was a profession. A few specified that it was a caring profession. This terminology may have been picked up in college during the Introductory Course, so it was important to probe the meanings students attributed to it. Students' definitions of profession sometimes disagreed, and some of their apparent differences of opinion as to whether nursing was a profession were based on the definitional differences rather than on disagreement over their views of nursing.

Mary Ann and Natalie were among those who offered "caring profession" as an appropriate label. One feature of nursing that made it a caring profession, according to Mary Ann, was that one joined it along with a group of other individuals, to commence training for a publicly recognized occupational field. She implied that the individual took on an occupational identity in joining the training for a profession. Mary Ann suggested that one didn't expect high earnings, but did expect satisfaction, from a profession. Her account of moving from the outside to the inside accorded with Natalie's implication of taking on an identity as part of joining a profession.

Angela offered a variation of terminology, suggesting that nursing was "a dedicated profession". Her explanation of this was too thin to define its meaning adequately, but the crux seemed to involve variety and a concern for individuals.

Other students offered the single word "profession" as a label, and the need for training and the notion of commitment were frequently offered as defining characteristics. In this regard, it was often compared with medicine, and occasionally with law and teaching.

To Carol, the idea of training for a profession also carried with it the notion of "learning all the time". Donna indicated that there was something particular about the training and learning:

- D - You're being a professional in a job, you're being trained for it, so you've got to have that ... like a doctor has to have sort of etiquette and things and he's got to ... trying to think of the word, but he's got to have confidentiality and all that sort of things. Well, nurses have to have that as well. They've got to act a certain way.

Several students thought profession was an accurate label for nursing, but could not say why, just that it sounded right.

Rachel was rather reluctant to use profession as a label for nursing, though she didn't discount it.

- R - It is a profession, but (...) if you're tryin' to say to somebody what nursin' was, I wouldn't use that word. (...) When I think of profession, I think of someone on a good salary [laughs], which isn't, well it doesn't quite fit, does it? Someone who's trained, with a qualification, that sorta thing. A certain status in society. (...) Apart from the money, yes, aye, it fits.

Valerie, too, seemed reluctant to label nursing a profession, but for a different reason. "It makes it sound a bit more formal. As if you're intelligent," she said, with a laugh. It sounded as if she saw it as something to do with image rather than substance, and as if she wasn't at all sure a nurse was intelligent. Frances said that nursing was "maybe not a profession."

- F - To me a profession would mean going up, and perhaps a nurse might feel happier actually working with the patients rather than administering the staff.

Oliver, having selected "career" as his first choice of label, went on to explain why "job" rather than "profession" was his second.

- O - Probably the choice is between job and profession. Profession has a sort of snob quality that, even if I were a surgeon, I would rather not say I was in the professions. (...) Reverse or inverted snobbery, that's what it is.

His choice seemed to be based more on the personal image he would like to project than on a clear definition of what constituted a profession.

The most common feature that characterized "profession" as an appropriate label had to do with connotations of learning, training and qualification. In addition, there was the idea of opportunity for promotion, which for some students made "profession" a positive fit and for others a negative one. A similar disagreement existed with the notion of the image or status entailed in a profession. A positive fit seemed to involve the idea of a profession's being something that one joined and belonged to, that conferred an identity to its members, and that required commitment. The counter to the label was that a profession might be something that entailed high earnings, which nursing did not.

Career

The notion of promotion was prevalent in relation to students' choice of the label "career". Gail suggested that a career involved dealing with people and taking responsibility. She and Helen both indicated that it connoted opportunities for promotion. Helen added that a career involved working with people and variety.

Ian suggested that nursing was a career not only because of promotion prospects, but also because there were opportunities to specialize. Zena also implied the notion of horizontal as well as vertical movement opportunities.

- Z - It's something that you can train and do and then, it's not just a dead stop after you've trained, you've got all the branches, you've got so many different ways to turn.

Natalie suggested that the prospects for movement were a matter for personal choice.

- N - It could be (a career), I think some people get very ambitious, and like to work their way up the ladder ... I think, as you work your way up the ladder you tend to get further and further away from the patients, you're bound to get more and more paper work, it's inevitable. (...) I wouldn't want that (but) I think I might be interested in doing other types of nursing.

Thus nursing could involve a promotional structure for those who wanted it, but need not entail it for those who did not.

Carol and Wendy both mentioned travel opportunities in a career such as nursing. Wendy saw this as an additional advantage.

- W - Well, I feel right now I can go anywhere, once I've qualified, and do anything. I can go into the services, I can go to Australia, anywhere. I mean, I can just make a career of it anywhere, and I'll never have to think, oh, I'm gonna have to get married and get a husband to support me, cause I'll have a career of my own.

Thus for her a career connoted a means of being self-sufficient, with implications of independence and opportunity.

For Yvonne, the characteristic feature that warranted that label had to do with the individual's motivation.

- Y - A career is something that you've been aiming for, like you could go into a job, and just be in any job, you know, but a career is what you've always wanted to do. (...) a career, your career is your decision, and it's your aim is to be.

For Tina, nursing was definitely a career, which is "something you get really involved with and it's part of your life." Donna's views were similar.

- D - It's a different way of life altogether. (...) It's part of your life, (...) it will change you. Part of you.

Frances saw this idea in a rather different light.

- F - It's partly career.

AK - Mm-hmm. What does that mean to you?

- F - It sort of takes you over. [laughs] (...) I think some nurses that have been in it for a long time and perhaps haven't got a family, aren't married, it is their life.

Her tone seemed to imply that this was not altogether a good thing, that being married and having family would obviate the need for something like nursing to become one's life or career.

Rachel was reluctant to say that nursing was a career, for her personal reasons.

AK - "Nursing is a career" — would that fit?

R - Em...yeah...yeah, cause it is, it's a, em...wait a minute...

AK - What does career mean to you?

R - That's what I'm tryin' to think, career...it means, it means not gettin' married!
[laughs]

AK - Ah, I see, so you can't have a career and get married?

R - Well, I s'pose... Well, like, cause I'm startin' when I'm twenty-one I tend to think that I'll be twenty-four before I finish, so I mean, I'm gonna have to have a coupla years at least, I would like a coupla years as a staff nurse before I got married or that, or before I have children, but then that puts you up to twenty-six, and then you think, oh well, another coupla years, twenty-eight, and I think, I'm gettin' a bittie old for kids now [laughs]. It all, actually, everything seems to revolve round kids and that sorta thing, so...I s'pose you can have a career and kids 'n get married as well, but I wouldn't like to combine both of them.

Rachel's account is reminiscent of Frances's, in the idea that one could either make a family one's life or make a career (nursing) one's life, but not both.

Julie was also displeased with "career" for nursing, because to her a career sounded like something one just went into to earn money and could therefore leave behind when one left work, and not something one had to study for. These features, in her view, were not true of nursing.

Thus there were many reasons why students thought nursing was a career, a few reasons why some thought it wasn't, and a notion that, in part, whether it was or not depended on an individual's own approach to nursing. Career characteristics of nursing included the prospect of promotion, a need for training and qualification, working with people, variety of fields, opportunity for travel, self-sufficiency, need for personal motivation and suitability, and a long-term commitment to something that would become part of one's self or one's life. Two features particularly mentioned as depending on the individual's own motivation were the idea of climbing the promotion ladder (one might want to or not) and the commitment to it as the primary element of one's life.

Suggested career features that did not fit included that a career could be something one didn't have a driving motivation to do, and was something one did for the money, that didn't require training, and that one could leave behind at the end of a work day.

An inspection of these views shows that the students differed on aspects of what they meant by career, but differed little on what they saw as characteristics of nursing. Most of these were also revealed in discussion of other labels, as well as in other parts of the interviews, and will not be belaboured here. Two additional features came to light, however. One was the idea of opportunity — for promotion, sideways moves,

and travel. The other was the possibility of a commitment to nursing blocking a commitment to other things, in particular, to marriage and children (and vice versa).

Vocation/Calling

The terms "vocation" and "calling" are considered together, because for most students who mentioned them, there did not seem to be a clear difference between them. These terms elicited contrasting views from the students, both as to the use of the terms themselves and as to the characteristics they denoted.

For some students, the feature that made vocation or calling appropriate was the individual's feeling of being right for nursing, or nursing's being right for the individual. "Vocation" was Pat's first choice for an occupational label because

- P - It's something you're called to do, not something you're going into just because it's there, but it's something you feel really deeply that you're right for (...) the only job you'd really be happy doing or getting job satisfaction out of.

Rachel's view was similar.

- R - (It) means that you've got a burning need to be a nurse. [laughs] It means that you think it's your destiny, that's what you've been put here for. That's what I think, a vocation.

Tina saw vocation and calling as equivalent, and she was happy with either as a label for nursing.

- T - I think it's like you're born, and you're going to be a nurse. You're born, and as you grow up, you sort of maybe think about all the different things going here, there and everywhere, and then, something just clicks, and you say well, nursing needs me and that's what I want to do.

Frances and Natalie each had a preference for one of these two terms and a reservation about the other, and for the same reasons, though in reverse.

- F - It might be a calling [laughs], but I always associate that with ministers. (...) ministers I expect hear a voice telling them this is what they should do. (...) A vocation, now that would fit it better.
- N - Well, I think it is (a vocation), but it gives it religious connotations [laughs], which I don't think, you know, if you took those out, I'd probably say yes, vocation's ... I mean, I would use that.

So both Frances and Natalie seemed happy enough that the general idea of calling or vocation fitted nursing, if the religious connotations were removed.

A number of students indicated that whether vocation or calling was appropriate was not in the nature of nursing itself but depended on the individual. Kathy said:

- K - It wasn't a vocation with me, because, I hadn't sort of thought of it since I was five years old, that I was to be a nurse. (...) It was maybe a calling, because of

personal experiences that I felt it would be a very useful and beneficial and you get a lot out of it.

Gail suggested, "It's probably a vocation for some people." As to what that meant, she said:

- G - More dedicated. Really that is what they want to do, and less interested in anything else. They're totally fulfilled by what they're doing in the wards. (...) (Less need for) any social activities or things like that, but their job. (...) I think it's better if you actually have a social life and things like that, because if you have it as a vocation, you end up by getting, having your job take over your life.

So to Gail, the label "vocation" was accurate for what nursing represented for some people, but she did not see that as a healthy thing.

Lorna said that nursing couldn't be a calling because "a lot of people drop out." She seemed to be implying that if it were a calling, people in it would not give it up, because they would have been called to it.

Some contradictory features of nursing were thus brought out by investigating the students' use of the labels "vocation" and "calling". On one hand, there was a view that the labels fitted, because one has to be right for nursing, feel a need to do it, and feel that it is one's destiny for life, but not in the same sense that one is called to a religious vocation. It might go to the extreme of taking over one's life, to the exclusion of other pursuits. On the other hand was a view that nursing did not fit these labels, because one might simply make a rational choice to go into it, and had the freedom to drop out, or to follow other interests.

BEING A STUDENT – BECOMING A NURSE

This theme arose from autobiographical elements in students' accounts which shed light on their images of nursing. They are divided into the following four sub-themes:

- sources of image,
- choosing a career,
- feelings about doing nursing, and
- becoming a nurse.

The extent to which these elements are interrelated makes it difficult to discuss each as a discrete entity. The least complicated in this sense is "sources of image", which is discussed first.

Sources of Image

All the students mentioned something about where they thought they had acquired their ideas about nursing. These sources involved contact with nurses, the media, careers material, and "unknown".

CONTACT WITH NURSES

Some students had had employment experience through which they had encountered nurses. Paid employment included work as a nursing assistant or auxiliary, as a ward secretary, or as a student nurse (previous attempt at training), while unpaid employment was either volunteer work or work associated with a pre-nursing or other health-related course.

Lorna's work in a home for handicapped children as a care assistant had sparked her interest, but she was aware of the narrowness of the experience as a source of career information.

- L - I never thought of doing nursing before I started working. (...) I really enjoyed it, but then when I was taken around the wards [during introductory course] I suddenly thought, oh! there's another side of nursing that I haven't thought about, and nobody'd actually said to me (...) think about general, and at the interview I think they were so desperate for people to do mentally handicapped...

It is interesting to note the incompleteness of the information Lorna had, which the nursing college did not appear to make an effort to identify or correct, and the necessity for her to make her choice of training before she knew enough about the different fields to make an informed choice. Given the fact that candidates are often viewed more favourably if they have had employment in a nursing-related job, it is notable that Lorna's experience seemed to have provided her with only a limited understanding of the occupational choice she was making.

Valerie had worked in a geriatric unit during a course in social care.

- V - I was near the end of my first year and I did a stint with the geriatrics. I thought, no, social work's no for me, think I'll do nursing.

She then got a job as a nursing auxiliary, and said she learned a lot about nursing by watching and talking to the trained staff.

Wendy was starting her training for the second time, having started a few years earlier and given it up during the first clinical week of her first module.

- W - I was very disillusioned. I think it was a mixture of being homesick as well. (...) We were taught everything in college and when I got out in [geriatric ward], they didn't do anything like it. (...) I think it was the fact that I came into it when I left school, quite open-minded, very immature though. (...) I was just sorta drifting into it. (...) We were taught everything in college and I just

expected that's how it would be in the ward, and ... the auxiliaries ran the ward, and the sister was never there — well, I was only there three days, but she wasn't there any of the three days, I never met her.

It became clear later in the interview that Wendy didn't expect reality to fit her initial ideal any more than it had on the first occasion but she believed she could now accept that fact; she believed that she had changed, not that nursing would have changed.

Rachel had done voluntary work on Saturdays at a local hospital for a year before she left school. This was in a general ward with mostly older patients. She had applied for nursing at that time, but did not get in, and went into accountancy instead. Malcolm had spent a week as a volunteer working on the farm at a school for mentally handicapped children, after having the idea to go into nursing. He enjoyed it, and this helped persuade him that he could get the satisfaction he was seeking in mental handicap nursing. Gail worked as a medical secretary in a geriatric hospital. She said that she "didn't enjoy it, secretarial-wise", but she expected to enjoy nursing in a similar sort of area.

Most of the students who had experience in nursing-related work said they had already decided to do nursing before undertaking the work. It was less common for them to have decided on nursing as a result of such work. In both types of cases, it was clear that their entry image had been influenced by their experience.

Some students had parents or other relatives in nursing, and this had variously been a cautionary factor, a positive incentive or, in at least one case, of little consequence to their images of nursing, according to their accounts. For Pat and Lorna, having relatives in nursing had nearly kept them from considering it for themselves.

P - Both my parents are nurses, my aunt's a nurse, my gran was a nurse, and I was saying, "Too many nurses in the family! I'm not being a nurse!"

L - I always hated the thought of being a nurse (...) just because my Mum was a nurse, and my Gran's one, and my cousin's been one, and I thought, ugh, I don't want to be another nurse in the family.

Both indicated that most of their early ideas about nursing had come from their parents.

Donna's mother had trained as a nurse and had told her about some of the less pleasant aspects of nursing.

D - ... you get all these nasty jobs to start with, the bedpan, get this, get that, just running around to start with (...) That was through my Mum. She told me a lot. She told me the nasty things, which was good. [laughs]

Malcolm's mother was also a nurse, but her being in nursing had not given him the idea of going into nursing himself. After leaving school, he had taken a job he found unsatisfying, and was casting around for something else to do. The idea of nursing

occurred to him as a result of watching the BBC2 series *Nurses*. His mother was a useful source of information for him, once he had the idea.

M - There was this nursin' programme on TV, and I says, aye, what kind of vacancies are there for male nurses, and my Mum just went, "What?", came as a complete surprise to her. (...) I sorta thought that this was somethin' that I could do, it just hadn't even entered my mind, cause if I'd thought about it before, I would have taken it forward a bit. (...) I asked my Mum what sort of fields there were available, and she said there's general, and mental handicap, psychiatry and sick children's. (...) I get most of my information from my mother, because she's a staff nurse (...) most of the picture I get is what she actually does, because she often speaks about it, it's elderly patients (...) it's just really speakin' about the problems with carin' for them (...) Speakin' about staff shortages ...

Sarah's parents were both health professionals. Their influence seems to have been related to their having exposed Sarah to a hospital environment as a child.

S - I was always in the hospital with my parents, and on holidays when there was nowhere for me to go, Sarah had to be brought to work, you know? [laughs] I was always there, stuck on this little seat, playin' with the exercise things, things like that. So I was always around the hospital, and the smell of it, and everything like that ...

It seems that many of Sarah's initial ideas about nursing came from a child's view of her parents' work place.

In Tina's case, it was a friend's mother she particularly remembered as having given her some early ideas about nursing.

T - My friend when I was little, her mum used to be a nurse, used to be a night nurse, and I can remember her telling me the stories and things like that.

Yvonne had visited a cousin who was a student nurse.

Y - That was really the first time I was in a hospital kinda bit, in [hospital] in London, and just, the uniforms, it was really the first time I'd seen the nurses with the cloaks and the hats and everythin' ...

Thus many of the students were aware of having heard about nursing from parents, other relatives, and friends, and a few indicated something about the ideas they had acquired in this way.

Quite a few of the students recounted exposure to nurses as consumers of their services, either indirectly, as visitors to friends or relatives in hospital, or directly, as patients themselves. For Mary Ann, having visited in hospital had given her ideas about what a nursing scene looked like, and Frances had similarly gained ideas about what nurses did.

MA - When my father was in [hospital] (...) it wasna a great big ward, but it was that kinda setup ...

- F - My mother (...) has bad asthma, and she's been in and out of hospital quite a few times. So I've seen what the nurses have done for her.

A particular experience involving a friend who had been in hospital seemed to have impressed Helen.

- H - (He) was burnt really badly. (...) It was the nurses I think that pulled him through. (...) He was blaming himself for causing his family all the trouble. (...) (The nurses) sort of cheered him up, you know, all sort of things like that.

Helen seemed to have been impressed by her view of what the nurses had done for her friend, which influenced her view of what nursing involved. She offered the above account to show why she believed nurses needed to have understanding, be good communicators, and take time to sit and listen to the patient's problems.

Students who had been patients in hospital had various memories of their stays. Kathy had been in a children's ward at age five, and she had some vivid recollections of that experience.

- K - It was in the days when it wasn't visiting all day, it was restricted to certain hours, and I just remember that the other patients in the ward with me were all, they'd either broken their legs and were in traction or they had burns (...) (The nurses) didn't seem to register at all. (...) I'd had a mole removed from my arm, and my right arm was in a sling, and (the sister)'d gone up to my mother to tell her that I was coping very well with eating, and my mum said oh, that's fine, but she's left-handed anyway, so it didn't make any difference. [both laugh] That's all I can sort of remember about the nurses. Oh, and the nurse taking the stitches out, and I was petrified. (...) I was quite excited about going into hospital. (...) I quite enjoyed it, because I got presents, my mum would come in every day with a little present just to help me ...

Kathy found that later consumer experiences altered her picture. Visiting both her father and sister in hospital, she found the physical set-up different from her remembered childhood experience.

- K - The wards were so different. Y'know, maybe only four to six patients in a sort of smallish section (...) it's a lot more, a cosier atmosphere.

She went on to say that although these experiences had altered what she really thought a nursing scene would look like, her typical picture had not altered accordingly, and she still pictured a big open ward with rows of beds.

Eileen had been a patient as a child, and it wasn't a happy memory. It seemed that this early experience had had a strong influence on her typical picture, although, like Kathy, her typical picture did not represent what she really thought nursing was like.

- E - I didn't enjoy it at all, I mean, the sister wasn't nice ... I was young, and I wasn't happy, I was wantin' to play wi' my toys an' that, and couldn't get out of bed. (The other nurses) were all quite nice, but they didn't have much time for you, and I was wantin' to play an' they were too busy.

Some of Tina's memories were from early childhood, but the most acute was of more recent origin.

T - Well, up to about four years old I was in and out (of hospital) all the time. (...) I didn't really remember much when I was little, because I was always getting put to sleep all the time, and I couldn't remember much. All I could remember was like sitting in a room with my mum and she used to tell me stories, and feed me, and I used to play, and that's all I can remember. (...)

AK - And then when you came in again when you were sixteen, how would you describe it then?

T - Well, like, the nurse was always there when you wanted her (...) They were all young nurses in my ward, even the sister (...) and they were all really nice to you. (...) Even though there was pain, I did really enjoy my stay in hospital, I thought it was really nice, cause they were all willing to sit down and chat to you. (...) I watched (the nurses) an awful lot after I was a wee bit better (...) and see what they did and everything.

Tina seemed to be saying that although she already had ideas about nursing before her experience at age sixteen, her ideas were positively reinforced at that time. In part, it seemed her perceptions were influenced by the motives which she imputed to the nurses (for example, that their intentions were always "nice" even when they were hurting her) as much as by what she actually saw in their behaviour. Thus her ideas were already at least partly formed, and she was interpreting her experiences according to those ideas.

Malcolm, too, recounted a positive view based on recent hospital experience, and his picture of a nursing scene, he said, resembled the ward he had been in, an orthopaedic ward. He had not been particularly uncomfortable and clearly had positive feelings about his experience as a patient.

In contrast to Tina and Malcolm, Carol did not enjoy her recent experience as a hospital patient at all:

C - I've once been a patient an' it was horrible. (...) The people in the ward I was in was nice, but I didna' like it. (...) I just hated the idea o' hospital, full stop. I was wantin' hame. (...) I was feelin' OK. I was just in for a wee operation ...

Her experience seemed to have no bearing on her desire to be a nurse, and its unpleasantness does not seem to have extended to her perceptions of the people involved.

There did not seem to be a pattern in the students' experiences of nursing, nor in how those experiences influenced their images. Memories were positive in some cases and negative in others. For some, the experiences had clearly influenced their images, while for others, their earlier images remained unshaken. In a few cases, it seemed the students' already-existing images influenced their perceptions of the experiences.

THE MEDIA

In this context, the term “media” designates television (TV) and written media apart from material specifically intended as career information, which is considered separately.

Most students indicated that TV fiction played a part in their images of nursing. Some were aware of having acquired some ideas from it, but most described their responses as being a recognition of what was realistic and what was not, in their judgment. Thus their responses revealed something about what, in their images, nursing was or was not.

Yvonne mentioned TV fiction in general.

- Y - Oh, all this love stories about the doctors! [laughs] I dinna think that would happen. (...) Sounds good, though! All this about doctors and nurses falling in love! No, I wouldna say, it's nae like that at all. (...) I think it would affect their work. [laughs]

Despite her mocking tone, she implied a certain appeal to the ideas suggested by such programmes. (“Sounds good, though.”) She seemed to feel she should espouse a disbelief of the types of situations they portrayed.

Students mentioned several TV fiction series involving nurses, including *Angels*, *Casualty*, *The Young Doctors*, *A Country Practice*, *General Hospital* and *St Elsewhere*. Becky made short work of a whole range of them, with a laugh, “I’ve watched all that rubbish.” She went on to say:

- B - Programmes like *Angels* seem to glorify nursing (...) they don't really show the hardships, all the bad things. (...) the hard work, I mean, you've got quite a lot to do (...) if you're working in like a geriatric ward where they're maybe all needing attention and you can't see to them all at once. (...) There's a lot of how the nurses feel to one another. (...) There's a lot of their lives.

Lorna mentioned *Angels* and *Casualty* specifically, and indicated aspects of agreement and disagreement with the images they projected.

- L - *Angels*, it's terrible! (...) Nurses are seen to be as just like angels, people who are perfect, and *Casualty* is a good programme, it shows that they aren't perfect (...) It shows people that when they go to hospital what kind of things to expect, that nurses aren't gonna be perfect. (...) (*Angels*) seems to be awful sexist (...) with suspenders under the uniform and all that kind of thing. (...) In the programmes they all seem to be slim with blond hair. (...) Which is wrong, cause it's not like that in hospitals. You've got to portray it properly, you know.

There are curious elements in Lorna's account. She is sceptical about *Angels* for showing nurses as perfect, yet she also criticizes it for being sexist with “suspenders under the uniform and all that kind of thing.” It is also interesting that she seems to feel that such fiction programmes have an obligation to show nursing as it really is.

Gail offered a similar assessment of the same two programmes, but Wendy's was virtually the reverse.

- W - I think (*Angels*) was a really good programme, cause it was so realistic (...) it showed you the muck an' them gettin' really fed up at the end of a shift, sore feet, in the nurses' home them not gettin' on (...) *Casualty*, that was on TV, and it was rubbish. Oh, I couldn't stand it. I just suffered it once. It was dreadful. (...) It was just the dialogue, it was the programme itself that wasn't realistic at all, just some of the things that were bein' said, you thought, oh well, no way that would be said.

Wendy seemed to be comfortable with the portrayal of difficulties that might be encountered in nursing, but disapproved of dialogue that portrayed nurses saying things to patients that were not right.

Zena and Tina did not see either *Casualty* or *Angels* as being realistic, but nor did they expect them to be.

- Z - Ach, I've seen them, but you know that's just something to make people watch it, just to entertain. (...) I don't think they seem very realistic. (...) They've never got anything pressing to do. I suppose in *Casualty* they did (...) to me it seemed false anyway. I liked the programme. (...) Like *Dallas*, you watch *Dallas*, you don't believe the story, but you still watch it. [laughs]
- T - I don't believe everything I see. (...) I like *Casualty* (...) but I didn't believe everything I saw in it, I thought it was quite good. (...) It's for like the public, and they want to hear all the scandal, and the gossip. (...) It's not really on to tell you about the hospital.

Unlike Lorna, Zena and Tina seem quite happy with the idea that TV drama can serve the purpose of entertaining without an obligation to be realistic.

Valerie was aware of having gleaned some of her ideas about nursing from *Angels* but now saw it as being unrealistic.

- AK - What made you think of doing [nursing] (...)?

- V - I think it was the sort of glamour aspect of it, dressed up in a nice white uniform and wearing a cap. (...) Just seeing on telly. I think, what was it, *Angels* that was on? I watched that quite often. (Reality is) totally different. From what I can remember, it's not like what I've experienced.

Mary Ann, too, acknowledged the early influence of TV programmes on her ideas about nursing.

- AK - You (wrote) that you've watched *General Hospital* and *Angels*.

- MA - Mm-hmm. That was when I was younger.

- AK - Uh-huh. Do you think that's where you got your first ideas about nursing?

- MA - Oh, aye. I always put my uniform on fin I watched it an' 'at. [both laugh]

Later she was asked whether she now thought these programmes were realistic. "Fit I can remember o' them," she said, "that would probably have to wait until I was on the wards." She was reserving judgment, it seemed, until she could comment on their realism from a basis of experience.

On her questionnaire, Sarah said, "I used to love programmes on nursing." This was followed up in her interview.

- S - I used to like *Angels* when it started (...) but it's not very good in the last few years. (...) *General Hospital* used to be quite good when it started, again, *Young Doctors* is absolute rubbish (...) the nurses are wearin' uniforms I actually hate, I mean, good grief!, but I still watch that.

Sarah's view of the deterioration in *Angels* and *General Hospital* is interesting. One wonders whether the change was in the programmes or in Sarah's perception of them. What seemed good to her when she was younger might not seem so as she grew older and less credulous.

Carol shared Sarah's view of *Young Doctors*.

- C - *Young Doctors* [laughs], I watch that sometimes. It's quite funny. (...) I enjoy *The Country Practice*, cause I think it might be like 'at (...) in the outback, but *Young Doctors*, I dinna think it's realistic at a' (...) It was basically mainly socializin' about a' th'affairs the doctors an' the nurses wis havin', but it's nae like 'at at a'. [laughs]

Carol seemed to be more critical of the programme she felt should be like the setting she expected herself to be in, but was willing to accept what was portrayed on the programme which took place in a more exotic setting.

Donna and Angela, too, were sceptical about the realism of the portrayal of nursing in *Young Doctors*, though Donna seemed to be arguing with herself a bit.

- D - You see (nursing) on TV, you know it's not like that, but you sort of think it might just be slightly like that, you know, just a bit like it. (...) *Young Doctors* and all that sort of thing. (...) You sort of think, well, all these sort of nurse programmes and doctor programmes have all run on the same sort of theme (...) so there must be something in it that's similar. You will find that it's not really. (...) You see all the doctors and nurses and they're all romanticizing about, and flirtin' with patients, and just being so like, *Dynasty*, and all that sort of stuff, and it's so false.
- A - There's *Young Doctors* or something on. I've watched that. [laughs] (...) They don't seem to be dealing in reality. It's just about relationships with doctors and nurses and things like that, but not true to life, I think.

Several students laughed about the programmes, as Angela did referring to *Young Doctors*. It wasn't always clear whether they were laughing at the programmes or at the fact that they admitted to watching them, an admission they sometimes seemed to find slightly embarrassing.

Students' accounts of TV fiction involving nurses had certain common features and others on which they differed. They disagreed as to the realism of *Angels* and *Casualty*, but there were common features in the elements perceived as being unrealistic, namely over-romanticization or over-glamorization. While it was possible to see *Angels* as being more realistic than *Casualty* or vice versa, whichever was seen as being realistic was the one that was perceived or remembered as showing nurses as busy, hard-working, and not perfect angels. The favourite word to describe unrealistic programmes was "rubbish". Students who mentioned *Young Doctors* were unanimous in seeing it in this category, primarily because their images of nursing, as they admitted to or were conscious of them, did not include the amount of socializing and romance it portrayed.

The apparent ability of these students to assess the realism in TV drama about nurses, at a stage when their own images of nursing were immature, is worth noting. Concern has been expressed for years in the nursing press about the failure of TV fiction to offer a realistic portrayal of nursing, as if it had a responsibility to do so. If these students are typical, perhaps the profession's anxiety is excessive. Two students were explicit in their view that TV drama was intended to be taken as fiction, and it was implicit in other students' accounts that they, too, were discriminating enough not to be deluded by the more imaginative portraits of nursing. One possible flaw in this line of reasoning was the evident early influence of such programmes on two of the students, Valerie and Mary Ann, at an age when they were presumably more susceptible to the potentially false pictures portrayed.

A related feature is the confidence expressed or implied by most of the students that they could recognize the difference between realistic and unrealistic portrayals of nursing. In other words, they had a belief that their current images of nursing were realistic. One exception to this was Mary Ann, who was uncertain enough to feel that she would reserve judgement until she saw nursing for herself. Another was Donna, who implied a degree of uncertainty when she said that she "didn't really know," that "you know it's not like that, but you sort of think that it might just be slightly like that," but she nonetheless had enough confidence to go on to describe the fallacies in the picture the programmes portrayed.

Students also mentioned TV documentaries that involved nursing, and their accounts revealed a high profile of the BBC2 series *Nurses*. This was mentioned by eight students. Several mentioned other programmes by name, and one student, Yvonne, said she watched any documentaries that came on.

Angela mentioned *Nurses* on her questionnaire as being helpful in forming her ideas about nursing. In her interview she said, "I quite liked the Accident and Emergency one, it was quite good"; and about the episode in a medical ward, "the nurses,

they had been quite attached” (to a patient that died); and about the psychiatric episode, “I think that one seemed to be more realistic.” She also mentioned *Hospital Watch*, but did not feel it was as realistic, because although “you saw a doctor being called out (for) an emergency coming in, I don’t think you saw as much of the nurses being hashed (...) as what it would really be.” Again, this student’s account shows a belief that she can recognize realism when she sees it.

Becky, too, mentioned BBC2’s *Nurses* on her questionnaire, having seen five of the six episodes. She believed it gave a realistic view of nursing, and said, “I think you probably get a lot of your ideas from programmes like that.”

Valerie felt that the BBC2 series had been realistic, but some episodes fitted better with her image of nursing than others did. Referring to all the episodes in general, she said:

V - I thought they were interesting. It wasn’t really what I expected. (...) I thought you might see a surgical ward, or whatever, but we never.

She didn’t seem to be saying that nursing as the programme portrayed it was wrong, but rather that what the programme selected to cover wasn’t what she expected. She indicated that the best fit was the episode that took place in a medical ward, “Cause it was really what I expected from nursing, (...) nurses doing dressings and giving out drugs and whatever.” She hints at an element that became explicit in some of the other students’ interviews, namely, that their pictures of nursing broadened as a result of watching *Nurses*. She seemed to be aware of which bits fitted with ideas she already had, but did not think the other bits were unrealistic, only that they weren’t the type of nursing she pictured.

Zena found that *Nurses* was not only informative, but put her mind at rest about a particular worry she had had.

Z - I saw the one for the psychiatric nurse. (...) And I saw the one Accident and Emergency. (...) (It) didn’t put me off, it made me feel, gosh that’s really what I’d like to do, and the other one (about psychiatry), I was really worried about it, but that really made me feel an awful lot better. Thought, well, it’s not maybe as bad as I thought it was gonna be. (...) It seemed to be very down to earth, true, that’s what’s gonna happen.

Again, it seemed that Zena saw any lack of fit as resulting from the limitations of her image in comparison with the breadth of what was shown in the programme, rather than any lack of realism in the programme.

Tina seemed to find it useful to look for information in TV documentaries.

T - A lot of the documentaries I watch, like *Panorama*, things like that, I think those are really good. (...) I watched one about three student nurses from their training to their qualification. (...) It wasn’t in great detail, but it just told you various things, and it showed you them like right at the beginning, cleaning

each other's teeth and making beds and things like that, and I thought that was quite informative, if you were wanting to be a nurse, I thought that was quite a good programme to watch.

She had only seen one episode of *Nurses*.

- T - I just watched one of them about the incontinence nurse. (...) I didn't realize there was a specific job for a nurse.

On his questionnaire, Malcolm mentioned acquiring ideas from *Your Life in Their Hands* and *Tomorrow's World*, but he had not been thinking of nursing when he saw them. As has been mentioned, seeing *Nurses* had been a critical factor in whetting his interest in nursing.

Gail, too, had found *Nurses* to be useful for her career choice.

- G - I think it helped form (my ideas) more fully, when I applied for nursing, I felt, well, I've always wanted to do it, but I hadn't really thought of what was actually involved, apart from, like, patients, (...) but seeing that brought it all together and the problems. It really sorta made it fit.

When asked whether any one of the episodes fitted better than others with the image she already had of nursing, she identified features that had come as a surprise.

- G - ... the psychiatry one, no uniforms and everything. The other one in the labour ward. (...) It was quite odd, seeing the mothers. (...) I thought it would just be a husband, you know. But it shows you the more, the wider aspects ...

She seems to have identified with the first of these programmes, and to have used the second to correct an element of her image. So although Gail had already made her career choice when she saw *Nurses* it provided her with useful information. The bits that did not already exist in her image she accepted as being realistic.

Carol mentioned two programmes whose names she could not recall.

- C - There was a hoose o' quines [girls] an' they were a' sittin' waitin' for their final results to come in, an' you seen the postman walkin' up to the door, poppin' them in, an' they were a' standin' aboot goin', oh, will I open them? But they a' passed. I remember wonderin' feelin', oh, I wonder if that'll be me in three years time? An' there was another een, it was aboot (...) rehabilitation hospitals. (...) I always associated it as old people (...) but it was young an' old, an' it was really interestin'.

This last point seems characteristic of the way students viewed the documentaries about nursing. Whereas they were quite critical of the realism in fictional dramas and were generally confident that they could spot the unrealistic elements, when they saw unexpected elements portrayed in documentaries, they did not tend to suspect the realism but broadened their pictures to incorporate the new elements.

Few students interviewed acknowledged reading about nursing in fiction books. Two who did were Frances and Sarah.

- F - I have read some fiction books, but not many. (...) There was one which is an old one, talking about their wartime experiences (...) And there was an American one which I think had been embroidered a little to make it more interesting.
- S - I like reading books about the hospital, thrillers and that, not serious books. (...) I like to read things like *Brain* and *Coma* and *Accident* and things like that, you know?

This particular finding, the near-absence of literary fiction in the students' accounts, was unexpected. Both an earlier study (Kiger 1984) and a survey for this study appeared to suggest otherwise, as was discussed in Chapter 2. In addition, during piloting of the researcher's interview technique, students did mention having read fiction about nurses, in particular *Sue Barton*. It was thought that perhaps the students interviewed for this study might have been unrepresentative of the larger group in this regard, but an inspection of the questionnaires from the other students in the three relevant intakes did not support this. Only four mentioned books about nurses, three of whom did not specify the books, while one said she had got ideas about nursing "through reading *Sue Barton* books when younger."

There are at least two other possible explanations for this unexpected finding. Perhaps the young people who read nurse books from the library are not the same young people who go into nursing. Just as some students in this study watch *Casualty* and *Young Doctors* for entertainment, youngsters who read *St Mark's* and *Sue Barton* may just be reading them for entertainment, as they would read books about ballet dancers, horses, and girl or boy detectives.

Another possibility is that the students had read such books in earlier years but did not remember them, or did not attribute any elements of their nursing images to them. The TV programmes they mentioned were perhaps fresher in their minds because they were more recent. It would be interesting to know the answer to this, but impossible to discover it from the data in this study.

CAREERS MATERIAL

Some students were exposed to careers material at school. Others sought it from a variety of sources, either by mail or in person.

Helen, who lived on one of the islands, gave the following account on her questionnaire:

I got my information on nursing from a careers convention held at our school. My ideas really came when I went to a NHS open day at our local hospital. We were shown around 2 hospitals which showed us every aspect of the job.

Zena mentioned "careers talks at school" on her questionnaire. She didn't elaborate on this in her interview, but emphasized the information she received from one nursing college she applied to.

- Z - They gave you an awful lot of information. (...) We went for interviews and (...) (they) told us exactly what we would be doing for our course for the whole time. They were actually better than this place for telling you what you were going to be doing. (Scotsburgh College provided) just a thin leaflet.

Angela found some information in her school library, and she, too, got useful information during the process of applying for training, though in her case, Scotsburgh College was the provider.

- A - I had spoken to careers teachers (...) and when I did send for an application form, they sent me a form and some information about the college. (...) It's clearly explained to you (...) when I came for my interview, they asked me what I knew, and what I didn't know.

For Carol, the career material she obtained was not very helpful, in that it did not give her information about what she felt she wanted.

- C - I read a career book on nursin', but it was very complicated, I thought. It didn't really explain it, (...) it just didn't give you an impression o' fit nursin' would be like (...) It was just mainly about qualifications you needed, an' things like 'at, I didn't think it was good at a'.

This view accords with the assessment of much of the careers literature surveyed for this study, as discussed in Chapter 2.

Malcolm particularly mentioned the lack of information about nursing at his school, which had traditionally been a boys' school.

- M - They never even mentioned the possibility of any boys goin' into nursin', it just wasn't even thought of, so it never really cropped up.

Mary Ann had sought information from a local job centre and was given a book to read and a list of colleges.

Oliver had said on his questionnaire that he had got ideas "from various health agencies." This was discussed at his interview.

- O - Having been around (council office) on occasions, I did know they had a career service, and one day I was there, I got some literature, I think, just a couple of brochures or something, on nursing, and just took it from there.

Two notable features of this area are, firstly, that there was little mention of careers material obtained from central sources, and secondly, that school careers or guidance teachers had a minimal profile in the students' accounts.

UNKNOWN

This is not a sub-category in the sense that the others in this section have been, but a comment on the diversity and apparent contradictions among sources to which students attributed their ideas about nursing. All gave some account of such sources, and most named more than one, but it was rarely possible for a student to specify the precise origin of her mental picture. This is not surprising, since such a concept is a mental composite built up over time from a variety of sources. The source of a student's total mental picture of nursing was thus virtually unknowable. Rachel's account illustrates this particularly well.

R - It's strange that I had that picture, because I've seen that many different wards, and different things on TV with wards and that, but em ...

AK - Did you ever read books about nursing when you were younger?

R - ... em, what was that one called, I read *Flight of the Wren* or somethin' ... gosh, no, I don't think I actually have. (...) I've read some Mills and Boones, but I've not got any romantic ideas about nursing or anything, like doctor and that sort of thing, I mean, I've read some of them, but, eh, no ... (...) you know it's stupid ...

Rachel's account serves as an example of the vagueness of some of the memories students had about where their ideas originated.

It seems that the sources of the students' images were made up of a constellation of factors, some of which could be identified and many of which couldn't, and there was considerable variety in what those factors were.

Choosing a Career

It had not been the intention to explore other career options students had considered, as they were not thought to be directly relevant to their images of nursing. However, students themselves brought them up, and it became obvious that this offered an additional angle from which to view their perceptions of nursing.

Students gave accounts of having been interested in, or having participated in, a wide range of other occupational fields, some of which had no immediately obvious similarity to nursing. Certain features that students saw as appealing in their image of nursing became clearer through discussing the various occupations.

It might have been expected that the other careers students would have considered would be health care related, and students did indeed mention such careers, as Tina did.

T - It was either nursing, physiotherapy or radiography. I went to radiography for a day and I was just bored out of my mind (...) they just stood around and chatted, took the odd x-ray, and that was it. (...) I thought about physiotherapy, but I'd rather get to know the patient more, and work with them more, rather than just sort of in for five minutes and out ...

Tina's views on radiography and physiotherapy imply that nursing is not boring, and nurses develop long-term relationships with patients.

Sarah had also rejected physiotherapy, but not because the work did not appeal to her.

- S - For physiotherapy you've got to be awfully good at physics and maths. (...) I wanted to be a speech therapist for a while. But there again you have to have sciences ...

An implication in Sarah's account is that for nursing one doesn't have to be good at sciences. Later she mentioned one of her other options.

- S - Every time I saw an ambulance, I had this pang, I wanted to know what was goin' on, I wanted to be there (...) I did want to be an ambulance driver. But I thought that nursin' would be kind of where you can get your overall everythin'.

For Sarah there was a common factor involving hospital work and the sick or injured which constituted the appeal of the careers she had considered. Oddly enough, she had elected to do psychiatric nursing, which did not seem to be much related to the nature of her attraction.

For Kathy, there were also two health-related options.

- K - I'd been accepted to do physiotherapy (...) I had an idea I wanted to do medicine (...) but by the time the highers came along I realized I wasn't going to get the subject grades I needed. (...) Physiotherapy was the second option, it's still quite a high-powered scientific thing but wasn't quite as demanding, but (...) I was better at geography (...) I knew I'd be good at that, and physiotherapy was a vocational subject (...) at the end of it, if I didn't like it, I'd be stuck with having to do physiotherapy. Whereas with geography, it was such a wide subject that I could have gone into anything. And it was only in my final year when I was sort of thinking about careers that I came back to the idea of nursing. (...) Physiotherapy still appealed to me, but I wouldn't have been able to get a grant for that. (...) Illness or disease and treatments and that always fascinated me, just reading about ... and the body, the human body.

Thus whereas for Tina and Sarah the appeal of nursing had much to do with people, for Kathy it was her interest in the subject knowledge related to illness and treatment.

Natalie, as a mature student and graduate, was attracted to the idea of working with people. Had she thought of going into such work when she left school, she said, she would not have chosen nursing.

- N - Then I would have thought, if I was going to go into medicine I'd go and be a doctor, something more academic. Cause that was important then. (...) If you had A-levels, you sort of had the ability (...)

AK - Did you think about going into medicine just now?

- N - Well, no, too much studying [laughs].

The implication here is that nursing does not require much studying.

The idea that nursing was not very academic seemed common in students' accounts. Ian, who came into nursing after several other jobs and a health studies course, said, "At school I was interested in things like doctor or anything like that, but I just wasn't brainy enough." Zena's view of the academic requirements was similar.

AK - What other sorts of things would you have done if—

Z - A doctor. [no hesitation]

AK - And what made you decide on nursing?

Z - Because to be a doctor I had to get such high qualifications, and I could have gotten it (...) but a doctor'd have been far too much studying and I want to live my life a bit. [laughs]

Like Ian, Zena indicated that the academic requirements for medicine were high, but unlike him, she was confident that if she had cared to put in the effort, she could have met the requirements.

Students occasionally alluded to academic disciplines, sometimes in relation to a career and sometimes distinct from vocational concerns. As has been mentioned, Kathy chose to do geography and only returned to thinking about vocational fields during her final year.

Wendy mentioned that she had enjoyed biology at school and hoped nursing would be related to that. "I maybe should have gone and done a degree in biology," she said, "it's too late now." She had done chemistry at college while working as a lab technician.

Two students had done accounting. Pat did it because she thought she was not ready to go into nursing yet when she left school. Rachel had wanted to do nursing, but had been turned down on her first application because she didn't get Higher Grade English, though she had nine O-grades, including English, and four academic Higher Grades — an interesting sidelight in view of the accounts of the students who saw nursing as not having high academic requirements.

R - ... so I went and did accountancy instead. (...) The job I had, it was actually accounts assistant, and if I'd been doing a lot of accounts, like maybe doing balance sheets and that, I would have maybe enjoyed it more, but there was an awful lot of office work. (...) The course itself, I enjoyed. (...) I was going to do my professional exams in accounting, but I didn't register, so I had six months to wait before I could go back to college, so I got a job in that time, and awful lot of time to think about it. My auntie said that Scotsburgh College weren't askin' people to have Higher English, they were desperate for nurses. I lived beside the hospital in (another city), and I kept seeing these ambulances come by, and it just sort of accumulated that I had to go back, so I just reapplied.

Like Rachel, a number of other students mentioned office work in an uncomplimentary light. Gail had worked as a medical secretary. She didn't specifically contrast it with nursing work in her interview, but she did make indirect comparisons.

G - I've always wanted to be a nurse. (...) Once I started secretarial work (my friends) thought "Maybe she doesn't want to do it," so it was a surprise when I actually did do it. (...) I've found something that I really want to do, and I think it'll give me a lot of satisfaction. (...) I like being with people, rather than being stuck in an office.

Gail indicated that working as a medical secretary did not give her much satisfaction, as it only involved indirect dealings with people.

Mary Ann had worked as a receptionist for an optician after leaving school. That seemed to have been merely to have a job rather than as a career choice.

MA - I sorta put (nursing) to the back o' my mind really, when I was lookin' at a job, money, stuff like that. Probably I was gettin' a bit fed up wi' school an' a job came along, so I took it. Lookin' back, it was probably a mistake. (...) I probably should have stayed on at school.

Later Mary Ann mentioned her work at the optician's again, alluding to its relevance to skills she expected to need in nursing.

MA - You get every sorta person, an' I met a few, I mean, I went in green, but I came oot learnin' quite a lot about folk. (...) We were taught to gie them the benefit of the doubt an' nae judge them. (...) When folk wid come to see 'boot their spectacles, an' you'd test them again an' again an' again, you get the same result but they still canna see, you canna just say, go awa', we've tested you an' they're right. You have to dee as much as y'can for them (...) You just couldna say, well, statistically you should be seein', so go an' see wi' them.

So it would seem that although this type of office work was not Mary Ann's present first choice, and had only been taken as a job for money, it had involved working with people and interpersonal skills.

Angela had also tried office work and believed the job had given her useful exposure to the working-with-people that nursing required.

A - I had always thought about (nursing). (...) I knew that office work wasn't really for me (...) but I felt I wanted to try it (...) just to see how well I got on, and I think I landed quite lucky, because the job I had was up in the hospital. (...) I think it was actually working in the hospital kinda made me ... nursing didn't take a back seat totally, but I wanted to get on with office work, see how I got on, but working in a hospital dealing with patients, I enjoyed it, so I think that kinda pushed me further.

A number of students had worked in jobs that might be loosely categorized as technical, though they differed markedly in other ways. Wendy had worked as a lab technician. Oliver had worked in "land-based mineral exploration," though he was

vague about what the work was. Natalie, who had done a science degree, had worked in computing.

- N - I used to work for a computer firm, and I was just so sick of working, you know, the rat race, everybody's out to (...) earn a good living, and perhaps get promoted, and I thought blow that, you know, doesn't really matter. People matter.

So again the idea of working with people, or perhaps for the benefit of people, came into the picture.

Ian had done a technical job in a branch of the armed forces as his first job.

- I - I was unemployed for a year first. I left school at 17 and joined (...) when I turned 18. (...) I signed on for nine years, but I didn't finish it. (...) (After that) it was sort of a variety. I was a ghillie, an assistant gardener.

Thus, in addition to a technical job, Ian had done some skilled or semi-skilled manual work. He then did a health studies course, through which he discovered an interest in nursing.

A few students had done unskilled jobs without intending to stay in them. Carol had worked in a supermarket, Malcolm in a fast food shop, and Valerie in a chemist's shop, for example.

A number of students had thought of going into other professional or semi-professional occupations. Mary Ann had "once thought about teaching," and Carol "wanted to be a vet when I was little wee, but I wasna qualified enough when I left school."

Police work had an interestingly high profile in students' accounts. Pat mentioned it in the very first interview, saying, "Until I stopped growing, I wanted to be a policewoman." In the second interview of the first round, it was again mentioned, this time by Lorna.

- L - Before I thought of nursing, I wanted to go into the police.
- AK - What made you decide you didn't want to go into the police?
- L - Well, I'm not old enough just now, and you need experience. (...) I don't think I'd be right for the police now.

One might have predicted that the most popular alternative career options for student nurses would have been related to health care. It therefore came as a surprise to have the apparently unrelated option of police work mentioned in both the first two interviews. It came up repeatedly in subsequent interviews.

Police work was not one of Zena's career choices, but she mentioned it as being similar to nursing in the motivation it required.

- Z - I don't think you could be a nurse if it was just for the sake of being another job, (...) same as a policeman, I don't see how anybody can to into the police

force just because it's a well-paid job, because it's, get some pretty gross things to do in there as well.

So in addition to the need for real motivation, nursing and police work also have in common, in Zena's view, that they involve "some pretty gross things to do."

Carol had been serious in considering police work.

C - I wanted to be a policewoman to start wi'. (...) I would still like to be a policewoman.

AK - Why did you not do that, then?

C - Because at the time I thought I wouldna fit it (...) I didna think I could handle the pressures. So I thought ... I always used to, would like bein' a nurse. (...) But 'er's still at the back o' my mind about bein' a policewoman ...

AK - Uh-huh. Do you see anything in common about nursing and police work, that would make you attracted to both of them?

C - Baith o' them you're helpin' people, an' it's basically the public you're workin' wi' in nursin' and in the police. An' police an' nursin' are baith connected in certain aspects, along wi' social workers if 'er's ony like battered babies 'n battered wives or whatever.

Carol seemed to see the occupations she was interested in as fields in which one worked with people or "the public" in situations potentially involving social problems.

Malcolm, too, had considered police work.

M - I knew I wanted to do somethin' that was worthwhile and I thought about the police, but then I changed my mind because (...) it is doin' a public service, but quite often it's not so much carin' as, you know, just carryin' out the law.

The implication here is that both nursing and police work are worthwhile and both involve a public service, but he sees a difference in the degree of caring entailed.

Understanding the students' images of nursing was thus enhanced through discussion of other occupational fields they had considered. A key feature was that nursing involves working with people in a particular way. This was variously described as helping, involving patients or the sick and injured, dealing with social problems, and developing relationships. Other occupations that shared some or all of these features included police work, medicine, veterinary work, social work, physiotherapy, and driving an ambulance.

Nursing was said to be worthwhile, as was police work. It was seen as interesting, not boring like office work, radiography, or certain unskilled types of jobs. It kept one on-the-go, was varied, and involved hard work, as police work did. To be a nurse, as to go into police work, required a strong desire or one would not be able to put up with the sorts of things that would have to be faced.

As a subject to study, nursing, along with medicine and physiotherapy, involved biology, illness, disease, and treatment. Unlike medicine, physiotherapy and social

work, it was not too academic. It was a career as well as a course of study, unlike many other subjects, and it entailed a salary, obviating the need for grant aid.

Some of these issues were explored further during later interviews, since their import was not fully appreciated until after many of the first round interviews had taken place, and they are discussed again in Chapter 6.

Students gave accounts of a variety of factors that influenced their choice of nursing as a career. It might have been expected that a family tradition in nursing would have given it a positive image as a field to go into. This was not always the case, as has been mentioned with regard to Pat and Lorna. It seemed that nursing was not initially attractive to them because it lacked originality value. However, that disadvantage was eventually outweighed by their perception of nursing as something that involved helping people.

Rarely a student mentioned a financial factor. In Malcolm's case, the idea of money came up in relation to what some of his friends were doing.

M - (My friend Robbie) just sort of heard, money and computers, so he just decided to do that (...) he just heard there's a lot of money in it ...

The appeal of money had not attracted Malcolm. Financial considerations were a concern for Kathy because she had already done a degree at university and used up her grant entitlement. This was one reason for going into nursing where she would receive a salary, instead of physiotherapy for which she would have needed a grant. Ian, who had spent some time being unemployed, said that in part, nursing to him represented having a job and a salary.

For some students, the drama or glamour in their image seemed to account for some of nursing's appeal. Valerie described "the glamour aspect of it, sort of dressed up in a nice white uniform and wearing a cap." Rachel and Sarah were attracted by the imagined drama, as characterized by their avid curiosity about ambulances.

Some students alluded to the relationship between aspects of their self-images and their choice of nursing, and this provided further information about their images of nursing. Some spoke of qualities related to interpersonal skills, an area already discussed in relation to students' images of the good nurse.

Sarah expressed some very personal feelings about the value of communication. Again the concept of helping as being central to her image of nursing came in.

S - I chose to do psychiatric rather than general, cause I just like to help people more. (...) If I've got a problem, I'm the type that sits there and doesn't say anything to anyone, (...) and that's why I'm wantin' to do psychiatric. (...) There's a lot of horrible things that have happened to me, and people are only finding out now, and some of them happened about five years ago. I feel that I've lived with that for five years, and I mean, I've not done too bad, but I mean, other people might, and so I think subconsciously I'd like to help people.

Ian came across as being quite shy, and he mentioned this in relation to his decision to do nursing. Having said earlier that he imagined one of the hardest things nurses had to deal with would be talking to people about death, he offered an example of what he imagined to be one of the positive things about nursing.

- I - It would be a wee bit of a push behind you, maybe. I'm sort of a quiet natured person, comin' from the country an' that, and to be able to go and do somethin' like tell the relatives (...) that maybe one of their family's goin' to die, to have to push myself to do things like that could be good as well. (...) It's something I'd like to be able to do. (...) I'd like to do it well, for these people.

Other students mentioned interpersonal skills, and some implied that a person should possess such skills to be right for nursing in the first place. Ian saw himself as not possessing such skills yet, and he wanted to develop them and hoped nursing would help him do this. He seemed to have two reasons for this goal: for his own personal development, and to be able help people with the acquired skills.

Thus the additional features of the nursing image discovered by this route included its ordinariness (if family members had been nurses), its being a job with a salary, and its potential for drama or glamour. The glimpses of the students' self-images in regard to interpersonal skills reinforced and fleshed out the image of the nurse as a skilled and supportive communicator or helper.

Feelings about Doing Nursing

This section considers students' feelings about the fact that they were now doing nursing, and how they believed others responded to their doing nursing. These accounts offered an impression of some of the less tangible aspects of the students' images of nursing. The responses of the male students are considered separately in this case because of the clear differences evident in their perception of the issues involved.

Pat said that when people heard she was doing nursing, "I think they treat you with a little bit more respect," and the reason for that was, "I suppose the image people have of nurses is almost like they're saints."

Valerie expressed a similar impression.

- V - I think people tend to take an interest in you more. (...) I think people tend to respect you more. (...) [laughs] You've got to sort of live up to what they expect from you, that's the only problem.

So the respect which she perceived was accompanied by a burden of responsibility, which fits with Pat's comment that people view nurses "almost like saints." The idea that other people found her more interesting when they knew she was in nursing was also expressed by Angela.

- A - You become more of an individual. (...) You say you work in an office, you're just another office girl type of thing, but if you say you're a nurse, people say, "Oh, a nurse!" There seems to be more interest shown if you say that.

Mary Ann described the way in which she felt people's interest had affected her identity.

- MA - The folk that have stopped me when I've been goin' home an 'at, there's so much interest in the street because I went away to be a nurse. (...) I went down the other Saturday mornin' to the town, and by the time I got doon the town, it had taken me so long, I'd met so many folk, and everybody was sayin', "Oh you're goin' away t' be a nurse!" and "How are you gettin' on?" (...)

AK - And how does that make you feel?

- MA - Guid! [laughs] (...) Everybody likes, seems to like you when you're a nurse, think good o' you.

Wendy described a similar response to telling people she was doing nursing.

- W - It's generally a really, "Oh are you?! That's really guid!" (...) That's mainly the reaction you get, "Oh, 'at's really guid!" (...) It's strange, really. Just because of the work they do that a lot of people wouldn't be prepared to do themselves.

AK - And when you get that, how does that make you feel?

- W - Guid! [laughs]

It was noticeable that often when students described feeling good about other people's responses, they laughed and appeared really pleased about it. Rachel described a good feeling with a slightly different slant.

- R - I feel really good, makes me feel proud of myself, cause it's what I've always wanted to do, I've actually got round to doin' what I want to do.

Her feeling seemed to have more to do with her own view of what she was doing than with the views of others about it. Carol said people's reactions made her feel happy, and also indicated her own feeling of satisfaction about choosing nursing.

- C - Like this weekend I was oot, an' people were sayin', "Oh, have you started nursin' yet?", an', "Oh, yes — Oh!" [laughs] I was proud. (...) Maybe it's cause I'm enjoyin' it, and because it's a respected job, in that it's one that's very important. An' if you're actually deein' it, it just maks you feel guid. [laughs]

About the response from friends, she said there were those who had gone to college who envied the fact that she was earning a salary.

Responses relating to nursing as employment occurred in other students' interviews as well. Gail mentioned it in a rather different light from Carol's account.

- G - I've had a lot of negative things, like, "Oh, you'll be going back to being a secretary quite soon, you won't like it." (...) I think, a lot of people I've told

will be more secretarialized, and they'll feel that, oh, it's a dirty job, but most people, like my relations, and my close friends, they're really happy. They think it's really good.

And when asked how she felt about telling people she was in nursing:

G - [smile] I'm really glad. It really gives me a buzz when I say, "Oh, I'm a student nurse!" (...) I think it's, I've just finally found something that I really want to do, and I think it'll give me a lot of satisfaction.

It sounded as if Gail, like Rachel and Carol, felt good about what she had chosen to do, as did the people who mattered to her, and the sceptical responses of others did not matter much.

Helen had had what she considered unrealistic responses from friends, who saw it as "an easy thing to do," which she disputed. She felt positive about her choice.

H - At least I'm doing something to help people, and they're doing business studies, I mean, what's economics going to help people with, learning that?

Once again the picture of nursing as being something to help people is reinforced.

The two graduates offered a slant on the views of others that fitted with Helen's account. Natalie said she would not have got a positive response to the idea of going into nursing when she first left school, because she was expected to do something "more academic" since she had A-levels.

N - I think they would have said, "Oh well, you could be a doctor." (...) I think my mother still thinks, she's said, "Are you sure?" and I think she thinks I won't cope with being disciplined, you know [laughs], have to bite my tongue a bit. She's probably right.

AK - She's more worried about that, is she, than the non-academic-ness?

N - Oh yeah, I think that's gone, I mean, I've done all that.

In relation to the response she would get from friends, she said, "It's quite good, really."

N - "Oh, that's marvellous!" (...) Just cause you're prepared to go in and start from, I mean, like a temporary's on the wages you can earn, (...) To them, it's not just the nursing (...) but it's you're sort of starting again.

Thus Natalie attributed the responses she got from people who were impressed with her decision to the fact that she had the courage to make such a major change well into her working life.

Kathy's friends had a less complimentary view of her decision to go into nursing.

K - My friends were quite amazed that I was gonna do nursing, they sort of saw it as a step backwards for me (...) I'd already got a degree, and they thought it was a bit demeaning of me to do it, (...) I was quite amused by their reaction.

She got this reaction primarily from people of her generation who were going into managerial jobs and looked down on nursing. They couldn't see why she wanted to do it and saw it as a dirty job. The older generation, she said, thought it was a good thing to do, as it had career prospects, was a secure job, and was appropriate for a girl.

A variation described by both Zena and Donna related to a difference in response according to age and sex.

- Z - Older people think it's great. (...) My friends think, Ooo, I just couldn't do that, but good luck to you, and the boys just think, oh, you're gonna be a nurse, you know what they say about nurses! [laughs]

When asked how she felt when telling someone she was doing nursing, Zena answered, "I suppose good," with another laugh. Donna, too, felt good about saying she was in nursing, but expressed the same type of view of the responses of her male contemporaries.

- D - I'm quite chuffed about it [big smile]. To start with, when I first started, I was dying for somebody to meet me and say, "Hi, what you doing?", "I'm a nurse now." [laughs] I felt quite pleased about it. But when I left m'old job (...) it was mostly blokes there (...) it was all sort of, "Oh, hey hey hey, nurse, nurse, oh look!", with suspenders and everything, and this is such a horrible image, I just hate it, and the amount of people that sorta think that you're gonna jump into bed with the next man just cause you're a nurse.

At another point in the interview, she had said that "people put nurses on a pedestal." So both Zena and Donna were aware of a split image they perceived in the responses of others, but both expressed positive feelings about telling people that's what they were doing.

Sarah and Eileen had another concern related to other people's expectations. Sarah said patients "expect you to know everythin', for some reason," even when you're only a student. Eileen said she wouldn't tell people outside of work that she was a nurse, because

- E - ...it would just be wrong, cause I don't know anythin' about it hardly. [laughs] But I think people think that you know everythin' and you're a nurse sorta thing, just if you're a student.

Sarah and Eileen seemed to be concerned that people would expect too much of them, because they felt that most people had little understanding of the different knowledge levels within the nursing ranks.

Looking at the female students' accounts of the responses they perceived from others, elements of the nursing image included nurses as being good, admirable, not very academic, earning from the time of entry, and having to do unsavoury tasks. Being known to be in nursing made a person more interesting to others. In addition, there was mention of the "loose woman" image sometimes perceived by the students'

male contemporaries, and of an unrealistic public view of how much a nurse, however junior, could be expected to know. Most of the female students said telling people they were in nursing made them feel good.

There was an interesting but probably not surprising difference in the nature of the male students' accounts. Oliver expressed some feelings that superficially resembled those of female students, but on closer inspection the resemblance did not go very deep.

- O - I feel quite proud of [going into nursing], because I've always enjoyed collecting skills. (...) I really enjoy having varied talents, and I just look upon it as another, and a very important one.

As for the response Oliver believed he would get from others about going into nursing, he had this to say:

- O - Surprise. Not because of my character, but because (...) of the things I've done in the past, and for the people who know me socially, because of the things I do socially.

He felt that his choice of nursing would seem incongruent to people who knew what his interests were.

For both Malcolm and Ian, who were younger than Oliver, their views on the responses of others had implications that it was not usual to think of boys going into nursing. In addition, their answers when asked how they felt about telling people they were doing nursing assumed that that issue was implied in my question.

Malcolm described responses he had had.

- M - My two best mates (...) when I sorta sprung it on them, they were surprised [laughs] (...) First of all it was just shock and then it was "What possessed you to do that?" and I sorta said that it was somethin' I'd been wantin' to do and I thought that it would be worthwhile and everythin'. (...) My best mate Robbie (...) he was the only one that'd been out with me at [mental handicap community] and he (...) tried to understand it, rather than just say, oh god, you know. So he's quite happy with it now, he thinks it's somethin' guid. (...) My mum, after the initial whys, she's quite happy with the reasons I've got, so she's very keen now.

Of his own feelings about telling people, he said, "That's something I'm not bothered about what people think." Because his account obviously assumed a sort of negative connotation that would be picked up by others about his doing nursing, I probed the issue further.

- AK - Your female classmates (...) what kind of response do you think they'd get?
- M - They'd get, oh that's guid. (...) You see, girls are supposed to care and everything, and boys are supposed to do macho things. [laughs]
- AK - So you think people respond positively to the idea of girls caring (...) that's OK for a girl, but they look on it slightly differently for a boy?

M - Yeah, what's his reason for it, sorta style, yeah.

So in one sense Malcolm is suggesting the same type of image that was portrayed in the female students' answers, namely that nursing, as a caring profession, was seen to be a good thing to go into, except that that image did not extend to males in nursing. There had to be some "reason for it," in the case of a boy, rather than its being naturally good to want to do a job that involved caring.

Ian's account had echoes of an element Oliver had described, that is, its difference from his other known occupations and interests, and it also contained the concern described by Malcolm.

I - Most of my friends knew I was in the Forces, so when I tell them that now I'm doing nursing, they don't understand it. Maybe it's because ... [laughs] ... different, it's almost opposite to what I did. (...) I've never had the mickey pulled out of me or anything.

AK - Uh-huh. Would you expect that, do you think? (...)

I - It wouldn't surprise me, no.

AK - Because you're a boy, presumably?

I - Yeah, mm-hmm.

It seemed clear that the responses of others to their career choice was a different issue for the male and the female students. Most defensiveness from the females had to do with nursing's presumed non-academic-ness or its sexpot image, while for the males, it had to do with their gender and the nature of the work. Being known to be in nursing generally made a female interesting to others and was a cause for pride, while for the males it implied a need to justify their choice of work that was seen as caring and feminine. This distinction has been well described by Segal who investigated the perceptions of and about male and female nurses in a psychiatric hospital.

Male nurses are suspect because they enter an occupation that is traditionally female. They fail to meet the expectations that are supposed to govern men's career choices, and so they are involved in a status contradiction between characteristics ascribed to men in our society and characteristics that are supposed to inhere among members of the nursing profession. (1962:37)

Hesselbart has suggested that this is particularly related to occupational status. Status loss does not occur when a woman enters an occupation such as medicine which is traditionally dominated by men, whereas a man entering a traditionally female-dominated occupation such as nursing is seen as losing status, which is not an acceptable masculine thing to do. Hence "women doctors win and male nurses lose" (1977:49).

Becoming a Nurse

This theme arose from students' comments about the experience of becoming a nurse, either as it was happening to them or as they anticipated it.

Many students commented on college or curricular aspects of becoming a nurse. In some cases they expected a heavy load of college work, in others they expected the majority of learning to take place at the bedside. Some were already having their initial ideas affirmed or refuted by their college experience.

Most comments about becoming a nurse, however, related to the clinical side of the students' experience. Many students pictured stressful aspects as part of that experience. For Wendy, who had started nursing five years earlier and given it up during her first clinical week, some of her ideas about the stress were related to a perceived inconsistency between what she had been taught and what she had seen in reality, and to relationships.

W - I was very disillusioned. (...) We were taught everything in college, and when I got out in the ward, they didn't do anything like it. I came into it when I left school quite open-minded, very immature, though. (...) The auxiliaries ran the ward, and the sister was never there, (...) I never met her. (...) I felt really let down thinking that's the way staff were, a lot of staff were, to patients, (...) just disappointed that it wasn't as caring as I thought it might be.

She felt that now she herself was different.

W - Because I've worked with a lot of people, I've realized that not everybody's gonna be nice to me all the time, there's always horrible people in every job. (...) You've just got to face it (...) just come to terms with it.

For Donna becoming a nurse meant going through the stress of learning to cope with involvement.

D - Emotionally the nurse is going to be in for an awful time, I think, to start with. (...) You can't be normal if you don't show your feelings to start with, but I think as time goes on, you sort of learn to control your feelings a bit more, but I hope I never get to the stage that I don't have any feelings at all. (...) I'm just scared of somebody just dying on you and you're gonna get hurt. You don't really think too much about the family, (...) you're thinking about yourself, you know. What you're gonna feel like. [apologetic tone] I feel just now, you know.

In Donna's view it was natural for a student nurse to find coping with such stress difficult, and becoming a nurse was a developmental process in which the student could learn to control the consequent feelings while retaining them, or could (less desirably) learn not to have them. Getting hurt was one of the risks involved in the process, and the student nurse going through it was bound to have her attention taken up with her own feelings before she could be really concerned with those of others.

Helen, too, mentioned her worry about having to cope with death.

- H - I'm doing sick children's, so when, if a child actually dies, you know, I don't know how I'm gonna cope with that, but I'll probably find out soon [nervous laugh].

Implied in this account of Helen's is that part of becoming a nurse is finding out how she would cope.

Carol had initially thought a student nurse would be eased into the work (and by implication the stress) gradually. She now thought otherwise.

- C - I thought basically it would be auld folk, older people I thought, but obviously not [laughs] (...) because I was told what ward I will be on (...) an' it's a medical ward, it's got heart attacks an' I thought, my god! [laughs] I'll run in th' opposite direction. [laughs] Somebody said it's a brilliant ward, so I thought, oh well, that's not so bad.

AK - So now you think it'll be younger people maybe than you thought?

- C - Aye, a lot, aye. Which could be embarrassin'.

There seemed to be two components of stress implied here by Carol: dealing with patients with heart attacks, and the embarrassment of dealing (presumably in personal ways) with younger people. Yvonne appeared to be feeling stress already, in the anticipation of her first clinical experience, and compounded by her preconceived picture of what a ward sister was like.

- Y - Sometimes it scares me, like I've just had this thing that all sisters are dour and get you into trouble and things, and I thought, Oooh! But they're not all like that. (...) [A teacher] is taking people that are going up to [general hospital], taking them to the sisters, so they'll know each other before they actually go. (...) Where I'm going is [psychiatric hospital] and they don't do that, so I'll just be going in. (...) They're going up during [introductory course] to visit them, you see, to visit the sister and talk and that, but I'll just be putten right in ... [wistful tone] Hopefully I'll be OK.

It was clear that Yvonne had been dwelling on this, by her reiteration of the facts. Becoming a nurse at this point seemed to entail uncertainty and insecurity due to the unknown-ness of what was awaiting her in her first ward. This was magnified by the fact that she was the only student going to that ward.

Rachel was worried about the stress of responsibility that might await her in her clinical assignment. This related to an awareness she had gained during introductory course of current nursing practice.

- R - I used to think it was task orientation as it's called, ye ken, like you were told to do something. (...) I think I would have felt maybe a bit more secure, if I had been actually told, "You must do this," you get a list of what you have to do today, and then workin' through it. In some ways, I think I might have felt a bit better, now somebody'll sort of say, "Right, these are your patients, do what they need to be done to them," I think, oh gosh! 'At scares me a bit. (...) It's just that I might forget something, something that's vitally important. (...) But I suppose I could list things myself, I don't know.

Rachel seemed to be trying to figure out where she was in the process of moving from imagining nursing from the outside to becoming part of it, trying to picture how she would actually act once inside, such as by listing things for herself. Her image was being modified in her attempt to imagine herself in an inside vantage point. This was suggested to her when she was discussing how aspects of her view were changing. She used the phrases "I don't think I really realized" and "That's what I used to think."

AK - So do you think your change in view is you moving from outside to inside?

R - Yeah, I think so. (...) Outside people, life before, you think the nurse, the doctor, and that's it, but now again I realize there's an awful lot more involved than just nurse and doctor. Much more involved. It's really good.

So not only was she aware of moving from outside to inside nursing, she was finding it "really good", despite the anticipated stress.

Lorna also implied the outside-to-inside transition. She alluded to the objective view that could be taken when learning about nursing as opposed to the subjective experience of actually doing it.

L - I'm dreading my first bed bath to a man. (...) I would feel really embarrassed (...) but if you show embarrassment then the patient's going to feel really uncomfortable, so I think the comfort of the patient is the most important thing, so you would just go about it as if you'd done millions of bed baths before and this one isn't any different, and just carry on, even though you're shaking. (...) You don't think of these things, you get told about them in college, and you think, oh yeah, no bother, and then when you go to practise it must be really quite scary. (...) I mean, once you've got experience, no bother, but it's just getting the experience.

She realized that doing this dreaded task would not be the same as learning about it, but she expected it not to be a problem once she had completed the move to inside.

Considering these accounts from Yvonne, Rachel and Lorna, it appears that there were three views to be identified from their current vantage points as novices: nursing as they had imagined it from outside; nursing from an informed objective view, as they were told about it in college; and nursing as they expected to experience it subjectively, as they moved to their first view from inside.

This theme was reinforced by Angela in a discussion of how being in nursing affected her identity.

A - To go into nursing, you've got to want to do it, (...) especially when you know what you're letting yourself in for. There's a lot of people couldn't do it ... I don't know, I think I would be able to answer that one better once I've done my first stint in the wards, you know, to see how I get on, and if I think I'm going to be able to cope with it. (...) You get a picture in your mind of what it's like, but it's different until you're actually doing the real thing. (...) I think I've got a kinda realistic picture. (...) You do have a picture in your head of what it's going to be like. It will maybe turn out different once you're actually doing it.

Angela seemed confident that she knew what she was “letting herself in for,” at least to the extent of knowing it took coping with and not everyone could tolerate it. On the other hand, she didn’t know about it yet in the sense of how she was going to cope with it.

A number of students indicated that a major part of becoming a nurse had to do with relationships. Tina had had a brief experience of speaking to a patient in a ward during the introductory course, and this first step into the inside of nursing had caused her some initial stress.

T - We were at [hospital] yesterday, and we got to chat to a patient. (...) She was an elderly woman, and I just really was nervous going, but once you sit down, after the length of ten minutes you were laughing and thinking, oh, what was I nervous about. (...) I think just with experience, and learning to chat to people and getting along with people and that. Just the way your personality is and trying to like mould it for your job.

So Tina was beginning to experience the actuality of being inside, having experienced some stress as well as its resolution.

Students who mentioned interactive skills as part of becoming a nurse seemed to see them as potentially difficult to master. Gail implied that part of the difficulty would be the pressure of time. Valerie thought inexperience would be the problem. As has been mentioned, Ian hoped that becoming a nurse might help him develop interactive skills. He seemed to see his quiet nature as a shortcoming and hoped that having to learn to communicate effectively would help him overcome it.

Sarah believed that part of being a student nurse involved a real change in the person.

S - In your trainin’ you change to become a nurse. You can’t be the same person. (...) It’s very rare that you get someone that is the ideal person for a nurse (...) you have to sorta be changed a bit, like you have to learn more understandin’ about people, because at seventeen, I may think I understand things well, but I’ve not seen very much o’ life (...) I’ve only seen what’s been around my little house, my town. (...) You are learnin’ all the time.

Her account again encompasses the idea that experience is necessary before becoming a nurse could be achieved.

Carol described what she felt the overall nature of the experience of becoming a nurse would entail.

C - I’ll be workin’, while [friends from school] will be at college just learnin’. I’ll be in college learnin’ an’ a’, but I’ll be gettin’ practical experience.

Carol’s view of “learning and working” was, at this point, a positive one. It did not yet contain any of the elements of conflicting pressure expressed by the students in Melia’s

study (1987). She saw it as an advantage she had over the experience of her friends who had gone to college while she went into nursing.

Several elements that made up the students' images of nursing were reinforced or added to the picture through these accounts of what was involved in becoming a nurse. Most elements of becoming a nurse as the students described it were clinical rather than academic. Stress appeared in several guises: anticipated interpersonal demands; the dread of specific tasks; the nature of certain aspects of clinical work; and the anticipated burden of responsibility for making decisions about patients' care.

Becoming a nurse entailed developing a set of skills, especially those of effective communication, and would result in personal changes for the individual student. Students would have to put up with aspects of the student experience they would not like, and this reflected an element of self-disregard, as discussed earlier. Some students indicated a recognition of the learning and working duality of the student experience.

Throughout the students' accounts, it seemed clear that part of what was involved in becoming a nurse was a move from outside to inside nursing, passing through a stage of beginning to know about the reality of nursing, though they would not really *know* that reality until they experienced it. Thus nursing appeared to be something that was only truly knowable by experiencing it.

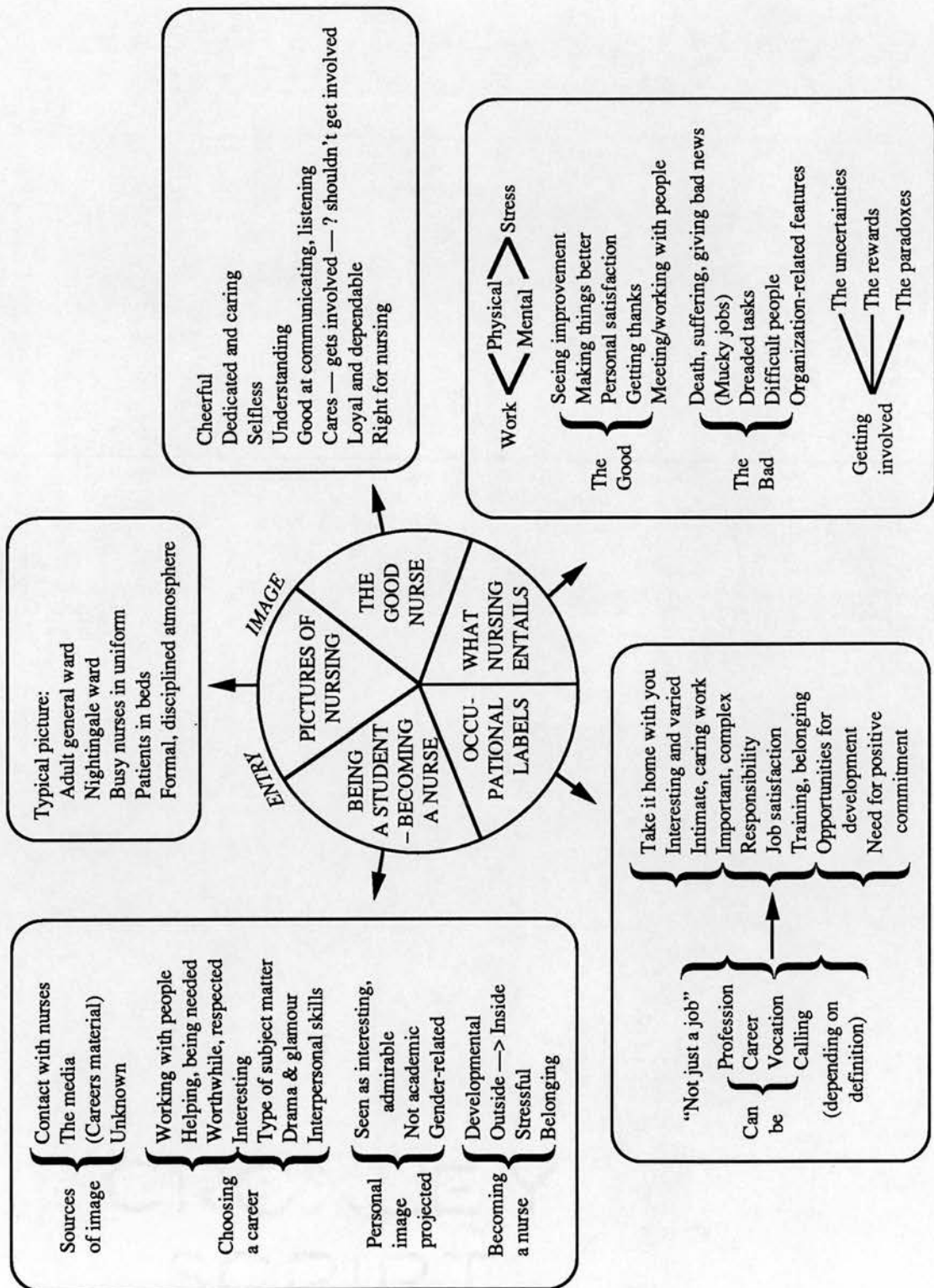
SUMMARY OF BEGINNERS' IMAGES

It is impossible to construct a concise comprehensive summary of the students' image of nursing as it emerged from the first round of interviews, because the range of elements was so diverse. It is possible, though, to highlight those image elements whose profiles rose above the rest. These are shown in diagrammatic form, as the categories of students' entry images and their properties, in Figure 5.1 (page 164).

Within students' initial images, nursing tended to be pictured as a scene in an adult, medical or surgical, Nightingale-style ward. The nurses in the picture were identifiable by their uniforms and caps. They were busy doing various tasks or spending time talking and listening to patients, most of whom were in their beds. The atmosphere was pictured as being formal and disciplined.

The good nurse in the picture was characterized by her cheerful countenance, caring attitude, dedication, selflessness and dependability. She showed understanding and was good at communicating, particularly at listening to patients' problems. The good nurse was in the unenviable position of needing to get involved with patients in order to be truly caring, despite the fact that this could be at great cost to herself, and she should not show her feelings. The ideal degree of involvement was a matter of

Figure 5.1



Entry image categories and their properties

disagreement, though there was a common perception that “they say” nurses shouldn’t get involved. Views were divided as to where the good nurse’s qualities originated, that is, whether the good nurse was born with them or attained them, but in any case, she was someone who was right for nursing.

In describing what nursing entailed in their images, various views of nursing work were offered by students. Some of these were physical in nature and some were described as being mental, and among these there were tasks and responsibilities that were seen as being stressful. Nursing was pictured as having both the good and the bad. The good comprised extrinsic and intrinsic factors. Extrinsic factors included seeing patients get better, helping patients get better, and getting thanks. Intrinsic factors included a personal sense of satisfaction from having done a good job and achieving personal development. The very basic fact of working with people was seen as part of the good. The most important element of the bad consisted of the various aspects of coping with death — communicating with the dying and the bereaved, dealing with a body, and coping with one’s own feelings of loss. Certain disagreeable or mucky jobs were acknowledged as being potentially bad, but not for the person who was right for nursing. Other bad elements included certain dreaded jobs, difficult people, and organization-related factors such as unsocial hours. As was alluded to above, involvement with patients and their families was imagined as a part of what nursing entails, and there were uncertainties implicit in this for the students, though often the involvement was seen as rewarding. This hinted at a paradoxical element in the students’ images.

As an occupational field, the strongest and most appealing feature of nursing was that it involved working with people in a helping relationship. It shared this characteristic with other health care fields and with police work. It was also like other health care fields in its subject matter (though less academic in its requirements), and like police work in that it entailed difficult aspects which could not be tolerated without strong motivation. It contained notions of glamour and drama. It represented employment as well as a course, but although one earned a salary from the point of entry, it was poorly paid, so one would not do it for the money. For this reason, among others, nursing was not just a job. It might be a profession, career, vocation or calling, depending on how these terms were defined. It offered prospects for promotion and specialization. It was enjoyable and varied work. It was a respected job, and students felt good about saying they were in nursing. There were, however, two types of reservation regarding the responses of others: for female students, young males often gave an unwelcome response based on nursing’s sexpot image, and male students were concerned that they might be viewed as deviating from accepted sex-role stereotypes.

At the time of the first interviews, the images revealed in students' accounts seemed to consist of a mixture of what they retained from childhood, what they had seen on television, and what they had encountered in personal experience, both before and since the commencement of their training. They seemed to have been influenced remarkably little by literary fiction or by school careers guidance facilities. Students were not always aware of the origins of the various elements of their images. There seemed to be a good deal of uncertainty and even mystery about much of the detail of their pictures, and some students expressed (often humorous) scepticism about their initial pictures, which they sometimes seemed to view as acceptably naïve.

An interesting feature of these aspects of the interviews was the way in which it was possible for the students to find things in their pictures that they didn't seem to realize were there until they were asked about them.

Another feature that underlay many of the students' accounts was a notion of belonging. They stated or implied that one took on a nurse's identity as one moved to the inside of nursing, and one's life and self would be changed thereby. Students indicated considerable uncertainty in this regard, as they were figuratively straddling the border between outside and inside the picture, so there was still a strong sense of unknown-ness about their images.

Chapter 6

IMAGES FROM THE INSIDE

This chapter considers the evolution of the students' images as derived from the data from second- and third-round interviews¹, that is, as the students experienced nursing from the inside. These might be thought of as their experience-mediated images. There were too many thematic elements to discuss all of them in detail, so the following discussion focuses on those that relate clearly to the themes identified from the initial interviews, plus new elements that emerged with a high profile. Throughout the discussion, students' accounts of their experience are referred to, as these constitute much of the evidence for the existence of the image themes, as well as evidence of the processes by which students' images developed, as discussed in the next chapter.

There was even greater overlap and interaction between themes during this stage of the study than had been present in the data from initial interviews, and the conceptual scheme into which the themes fit is not linear, so there is no immediately obvious starting point for the discussion. The discussion therefore follows the same plan as the previous chapter.

Three points about students' accounts from the later interviews are worth clarifying in preparation for the discussion. Firstly, the meaning of "image" was rather different from its meaning in the initial interviews. Initially students tended to describe the various aspects of their images as if they were spectators. Even when they imagined themselves in the picture, as they often did, they spoke as if viewing from the outside. In the later interviews the students were viewing nursing as from the inside; they were now actors within the picture. Thus their experience-mediated images had to be distilled from accounts in which they were interwoven with many other features of the students' nursing experience.

The second point is that notions of the good and the bad permeated many aspects of the students' inside images. Its presence is therefore evident in many sections of this chapter, but its specific elements are directly addressed in the corresponding section of the chapter.

The third point is that it became obvious during the later interviews that what students thought they remembered their initial images to be was not necessarily the same as what they had said at the time. During Julie's second interview, for example, when I read out a short extract from the transcript of her first interview, her response was, "I'd forgotten I said that, but I think I quite agree with myself there." In similar circumstances, several students responded with comments such as, "Did I say that?"

¹ These will often be referred to as "the later interviews". This should not be confused with those first-round interviews which took place later than others, or later than some second-round interviews.

Ian indicated that he was aware of possible gaps in his recollection when he said at the end of his third interview, "There's one thing I wondered, I just wondered if there was anything you'd asked me and my opinion had changed." He seemed to take it for granted that I had access to his earlier views in a way that he did not.

This phenomenon is interesting in light of quotes from students that are sometimes offered in journal articles or research studies, in which students have made comments such as, "When I first came into nursing I thought...". Since the students in this study were followed longitudinally, it was possible to compare what they actually said at the start of their training with what they claimed later to remember, and given the inconsistencies this showed up, it appears to be unsafe to take their retrospective accounts as an accurate reflection of earlier perceptions.

Because quotes in this chapter are drawn from two sets of interviews, in addition to identifying students by code name, a number is appended to indicate whether the quote is from a second-round or third-round interview.

PICTURES OF NURSING

This theme was thinner in the data from the later interviews. In part, the reason for this is that some of its elements were no longer relevant, as was the case with "childhood pictures". In addition, the discrete elements of the pictures were less easy to identify due to the students' being on the inside of the picture. Their overall image seemed to be more amorphous and widely inclusive, almost a representation of their total surroundings, but it was possible to identify changes in selected components of their initial images in this regard.

One simple component that students assessed for its match was the physical environment. If their typical picture had been of a Nightingale ward, for example, and they had worked in such a ward, they tended to continue thinking of it as typical of nursing. Angela had pictured a big open ward full of beds, and her first ward had been that style, but her second had not.

A - ... all these single rooms, it's not what you picture at first, not like I pictured before, whereas in my last ward there was this big open ward. (2)

When asked what she would now picture in a typical nursing scene, she said, "I think it would be an open ward, actually," so it seemed that her initial typical picture had been reinforced.

Some students whose pictures had not been reinforced altered their images accordingly. Mary Ann's typical picture had also been of a big open ward with beds down the sides, but neither her medical ward nor her surgical ward had been that style. The first had been made up of small wards of four to six beds, and she came to see that as

typical. She then “got a big shock” when she arrived in her second ward, which had single rooms off a long corridor, but after working there she found her first ward looked very odd when she went back to visit. It seemed that her typical picture was displaced by whatever style ward she was working in, and thus her experience-mediated picture was malleable.

There were other students whose initial physical pictures persisted although they had not been reinforced. They tended to believe that the lack of match so far was only because they had not yet been to a clinical area that was typical. Some described typical pictures at this point in virtually the same words they had used initially. The wards Rachel had been to in her first two modules had not matched her initial typical picture, but that picture persisted in relation to the experience she was anticipating in her next two modules.

R - I was just thinkin' (...) wait till I get to my medical ward, and I'm rushin' about with bedpans, and ... yeah, I can see it straight up and down, you know, beds perfect, corners perfect ... (2)

Valerie's picture persisted even after four modules, and it demonstrated the persistence of her image of nursing as general nursing rather than her own field, mental handicap. When asked to describe her typical picture, she said,

V - There'd still be a ward wi' nurses in uniforms and hats and patients in beds. (3)

This was typical of an overall similarity between the students' initial pictures and their experience-mediated pictures, namely that they still pictured adult general nursing as typical, regardless of the field they had chosen. Some differentiated between various pictures, and some seemed to see only general nursing as real nursing.

A few students were unable to recall their initial typical pictures. Eileen had had a very detailed picture, apparently of many years standing, which she had described as “weird”, and when asked in her second interview if she remembered that picture, she answered, “No, what was that?” When the account of it was read out to her, she said she couldn't bring it back to mind at all. Zena similarly said, “I can't really remember what I expected now, you know” (2). In common with a number of other students, she no longer had a typical picture. This seemed to be accompanied by a differentiated image of what nursing looked like. That is, such students had images of a variety of specific wards, or specific types of wards, rather than any longer imagining one type of scene as typical.

For those students who had not yet had a module in general nursing at the time of their second interviews, it was often the case that their nursing picture retained its original naïveté. This was hardly surprising, as for all the students but one, their initial pictures had been of a general nursing scene, as was discussed earlier. Lorna, for

example, who was doing mental handicap training, had had a module in sick children's nursing and one in the nursing of mentally handicapped children by the time of her second interview, and when asked, "If I just said the word 'nursing' to you, what picture would come into your head?", she responded:

- L - ... a nurse in uniform standin' by the bed of a patient, like you see on the front of books, you know. (...) See, before I came in, that's what I thought nursin' was, just like general. I never had any thought there was handicap nursin', sick kids. (2)

Thus it tended to be after they had had general experience that students had the most to say about whether their initial picture and their experience-mediated picture were similar.

Many students had acquired less formal images of nursing than those in their initial pictures. One of the major reasons for this change seemed to be that in many of the clinical areas in which they had worked, the use of first names was broadly acceptable. This applied to the use of names by other staff and patients, though in many cases, particularly in general settings, the ward sister or charge nurse was still given her or his title and was more likely than other staff to call the students by their surnames. Most of the students liked the unanticipated informality, and also accepted the difference maintained by sisters and charge nurses as being appropriate. Donna gave an account that demonstrated this.

- D - (In children's, first module) you always called the staff nurses and sister their last names, and they called you by your last name as well. (In mental handicap) it was all first names, cause it was so informal, and it was family sorta thing. (... In medical) Sister liked everyone to be called by their last names when she was there, but if Sister wasn't there you'd call each other by your own names, but 'at was just her way, she liked to be called "Sister" and she liked everyone else to be called by their, like "Nurse Smith", that's just what she liked. (...) In here (surgical) it's first names, (...) staff nurses, you call them all by their first names (...) and they introduce themselves to the patients on first name terms as well.

AK - What do you prefer yourself?

- D - I much prefer my first name, cause it's more, you put up a barrier straight away if you say "I'm Nurse Smith." (3)

Like Donna, many students developed a differentiated picture of formality, with children's being the most formal, medical and surgical being less formal than they had initially imagined, usually only the sister being called by her title and surname, and psychiatric and mental handicap being informal, with everyone, including charge nurses and nursing officers, being called by their first names. One apparent feature of this change in their images was that students felt more comfortable with the more relaxed nature of their revised images.

Many students seemed to have lost their initial pictures of a nurse. Zena, for example, had had a particularly colourful picture of a nurse in her initial image, and this had completely disappeared by her second interview. She said she had no typical picture any longer.

Thus students' pictures of nursing, after experience, were more diverse than they had been initially. There was still a tendency for them to have characteristics of general nursing, though differentiation also appeared. There was more variety in the pictures with regard to features such as formality and physical layout. In a number of cases, students had lost their awareness of their initial pictures.

THE GOOD NURSE: STAFF, GOOD AND BAD

In the first round interviews students described their images of the good nurse. During the later interviews, the continuation of this theme became evident in their descriptions of staff. Once they had had experience in clinical nursing, students' accounts provided clear indications that there were features of staff attitudes and behaviour that could be categorized as positive or negative, from the students' perspective. Thus their experience-mediated images contained not only the good nurse/good staff but also the bad nurse/bad staff.

The first clear examples of this became evident during early interviews in the second round, and one clinical area in particular engendered accounts that gave the bad nurse/bad staff side of the theme a high profile. A number of students had been to wards in this area, and their accounts consistently showed a negative picture. As interviews proceeded, it became obvious that there was also an obverse version of the category. Thus the two sides of the theme had complementary sets of properties.

In addition to gaining a bad version, this component of the students' images gained another dimension. Their initial descriptions of the good nurse had only implied one object of the good nurse's qualities, namely the patient. Now that the students' images had a basis in their own experience, they also perceived themselves as objects of good staff or bad staff attitudes or behaviour. In this regard, it became evident that students perceived a corresponding influence on the quality of their own clinical experience.

Students' images of bad staff were characterized by features that related to staff behaviour, and to attitudes and motives that were attributed to the behaviour. Students described staff members who were unfriendly and made them feel unwanted and unwelcome, who seemed either not to remember or not to care what it was like to be a student. Valerie and Helen, for example, described such staff:

- V - Somebody that doesn't introduce themselves to you, or make a point to know what your name is, cause I've come across that. (3)

H - We were made to feel at the bottom (...) The way they treated us, you'd think they'd never been students before. (...) The sister hasn't even said hello to me yet. (2)

The sister Helen spoke of was in her previous ward, in which she had spent a full thirteen weeks.

The bad staff were impersonal and did not seem to know the students as individuals, usually calling them "Nurse" instead of using their names. They sometimes were not aware of the students' stage in training. They tended to be more hierarchy-conscious than staff who were perceived as good. They maintained an us-and-them attitude towards the students, often taking segregated breaks. As Donna described them,

D - There was a lot of bitchiness and that. (..) The staff sorta were like little hitlers. (...) The students were just there to wipe your feet on. (...) I expected the staff to be all for gettin' the students trained and sorta fine, but when you get there you're treated like dirt. (2)

And Julie described working with such staff:

J - It's very much us and them, you know, students and trained staff not mixin'. (3)

Bad staff did not give praise and only gave feedback if a student had done something wrong. Such feedback might be given in front of patients and other staff, sometimes without getting the offending student's explanation or version of an incident. Sarah offered a graphic example of this in relation to one member of staff:

S - ... one day she just absolutely yelled at me in the ward for, it was somethin' that I hadn't even done, but she never even gave me a chance. (3)

Other researchers, too, have found this to be a prominent feature of students' negative experiences of training. Birch (1979), in a study of first- and second-year student nurses, identified "Being shown up on the wards in front of patients and staff" as a highly ranked stress area. It was second only to "Nursing of patients in great pain" after eight months of training, and second only to "Understaffing" after twenty-four months, as a cause of stress. Sellek, in a survey involving students from all three years of basic nurse training, found:

The term 'dressing down' was used on numerous occasions and many referred to 'being told off' in front of others. The students wrote with great fervour when the 'other' was a patient or when they felt that the criticism was unjust. (1982:139)

Students in the present study indicated that feedback was often not passed on to them until a formal assessment point, and a student then tended to feel she had been

deprived of the opportunity to improve her performance. Lorna indicated this sort of picture when describing a setting which to her exemplified bad staff.

- L - They just left us in the ward by ourselves, I mean, they're not allowed to do that as such, and if anythin' went wrong, they blamed you. But you never got any praise for what you did do right. (...) They wouldn't speak to you, even when you went for coffee breaks. (2)

Menzies identified this same feature of nurse training in a study of the functioning of a nursing system within a hospital.

The traditional relationship between staff and students is such that students are singled out by staff almost solely for reprimand or criticism. Good work is taken for granted and little praise given. Students complain that no one notices when they work well, when they stay late on duty, or when they do some extra task for a patient's comfort. (1960:31)

Bad staff, in the present study, seemed to expect students to make their needs known to them. That is, they did not seem to perceive the students' need for teaching or other forms of support. They did not explain things to students, and did not let them know what was going on in the ward. They were often perceived as being lazy, leaving the students to do all the work in the ward while they (the staff) stayed in the office doing paper work or socializing. They expected students to do dirty work that they were unwilling to do themselves. At the same time, they could be inconsistent in their behaviour and in their expectations of students. Ian and Malcolm both offered pictures of this, Ian from his current experience in a surgical ward, and Malcolm from a previous ward.

- I - ... here, you seem to be so often by yourself with another student, and you're never quite sure what to do. (...) when you're unsure and you're by yourself, it's so easy to imagine that you're not doin' well or it's so easy to feel a fool or as if you've done something wrong. (2)
- M - ... bein' checked over just doin' somethin' like normal BPs and a' that, over your shoulder (...) and then the next thing she'd be away for her tea and there'd be ill patients in the ward and there'd just be two students sittin' there, left with it. (3)

Additional characteristics attributed to staff perceived as bad included that they tended to be unenthusiastic or unimaginative, they were likely to prefer students to do busy work rather than to talk to patients, they intimidated students and were crabbit and often bitchy among themselves, and they did not demonstrate teamwork and were not seen as being caring towards patients. It was clear that the students' pictures of bad staff carried with them a picture of an unpleasant work atmosphere. Mary Ann indicated this in relation to a setting which to her fitted the bad picture.

- MA - It wasna a very good atmosphere and that. (...) There was a lot o' nastiness towards each other, complainin' between the staff. (3)

It should be pointed out that not all bad staff showed all these characteristics, and that not all staff who possessed any of these characteristics were necessarily considered by the students to be bad staff. In other words, there was a composite set of characteristics which constituted the students' image of bad staff rather than necessarily describing individual staff members.

It should also be stressed that although virtually every student had had some experience of bad staff by the time of the third interview, bad staff were not typical of the majority of the clinical areas in which students had worked. The importance of this conceptual component of their inside images cannot be taken lightly, however. Experience with bad staff had made some of the students contemplate leaving nursing, and had coloured students' views of certain types of nursing. If, for example, a student had encountered bad staff in her geriatric module, this very likely put her off geriatric nursing, because the image of all geriatric nursing was now bad. In addition to these obvious negative outcomes, it is also possible, though unmeasurable, that students' own subsequent attitudes and behaviour may be adversely influenced by the attitudes and behaviour of bad staff. Mary Ann's and Carol's accounts provide evidence of this.

MA - I think it must ha' been about that time, my third ward, that I began to sorta wonder, get doubts ... (3)

C - I'd had two good wards previously, before I was sent out to (hospital). I think if I'd been putten in there to start wi' I wouldn't have lasted. It just disheartened me completely, and I just felt so sorry for people that were startin' there in their first ward cause it was enough to put anybody off, a shame. ... It's the staff that make a ward. (3)

In relation to good staff and bad staff, Wendy said,

W - The staff can make or break the ward for you, you know, and if you get good staff, fair enough, but if you don't ... (3)

As her comment indicates, just as bad staff can "break" a clinical experience for students, good staff can "make" it. Here again, students' accounts provided a picture of their experience-mediated images, and there was little if any disagreement over the features that constituted good staff.

Such staff are friendly, relaxed and welcoming to students. They introduce themselves, learn and use students' names, and treat students as individuals, enabling them to feel part of the team. Lorna and Sarah described good staff that fitted this picture.

L - It's just so relaxed, everybody's so friendly, you can speak about anythin' and they're always willin' to listen. (2)

S - They're more friendly, they don't sort of make you feel as if you're so stupid. (...) They're always the one to answer things, no matter how many times you ask them. (...) If there's somethin' happenin' they'll come to you and say, have you ever seen such-and-such, and that makes you feel good, cause you think, oh

hey, they're thinkin' about me. (...) Just friendliness, you know, just askin' you how you're doin' and things like that ... (3)

The good staff of students' images recognize when students are in need of support and offer the needed support. They provide varied learning opportunities and keep students informed of what is going on in the ward. They are approachable and willing to be asked questions, even stupid ones. They don't expect more of a student than is reasonable for the student's level of experience. They are available when needed for advice or guidance, but allow students an amount of independence appropriate to their level of experience and ability. They provide useful and timely feedback, both positive and negative, and thank students for their work at the end of a hard shift.

Good staff provide positive role models in relation to the quality of nursing care they give. Becky offered an example of this, as did Eileen.

B - I think they've been really good at dealing with death. Just the little things, like when one lady died, there was always somebody with her, it didn't matter how busy we were, always somebody sat with her. (3)

E - ... it was just a good efficient ward, everyone was cared for, they got the full nursin' care, and it was a happy ward, even although it was cancer patients ... the staff were very good at explainin' things, they had plenty time for you ... (2)

Good staff are seen to muck in with the work, often working alongside students and serving as positive and active role models. They believe in the value of talking to patients. They show respect for students, never criticizing them in front of patients or other staff. They are respected by students, regardless of the degree of formality with which they run the ward.

Overall, the attitudes and behaviour of good staff in students' images combine to form a good atmosphere in the ward, which is then a happy place to work. It is possible to "have a good laugh" (Tina 2) when working with good staff. They have the ability to make a difficult situation become a good experience. Students may find they enjoy working in an area of nursing they don't really like, if the staff are good. This happened with Yvonne, who said about a ward that she expected to hate:

Y - Everybody was so nice. It was like everybody was on the same level (...) we just did equal work, cause it was a heavy ward, and everybody did equal, it was brilliant. There was nane o' this somebody sittin' in an office and leavin' us to do everything. It was brilliant, a'body just mucked in. (2)

There was a wealth of student comments describing good staff in addition to those offered above, of which they are representative. It was noticeable how often the same components of the pictures were described, sometimes in virtually the same words and phrases.

Thus the goodness or badness of staff seemed to make all the difference to the students' learning and enjoyment of a clinical experience, and to their own personal and professional development during that experience, as the students perceived it, and these factors affected the role staff played in the students' images of nursing.

Many earlier studies have revealed similar features in relation to the influence of staff on students' experiences. Birch (1975:55) found that among leavers from nurse training, 98% mentioned "poor staff relationships" as a contributory reason for withdrawal, a rate nearly double that of the second most cited reason. In Orton's study of ward learning climate (1981:42-46), characteristics of high student orientation wards and low student orientation wards followed very closely the description by students in the present study of good and bad staff. Fretwell identified an "ideal type" based on students' comments about what was good for their learning in clinical areas, and she enumerates the characteristics of ideal staff:

Sister and trained nurses

- show an interest in the learner when she starts on the ward;
- ensure good learner/staff relationships;
- are approachable, available, pleasant yet strict;
- promote good staff/patient relationships and quality of care;
- give support and help to learners generally;
- invite questions and give answers;
- work as a team. (1982:40)

It can be seen that her summary is very similar to the good staff images of students in the present study. Hyland *et al* (1988) found that among students who had completed eight weeks of nursing experience, there were accounts of a high incidence of trained staff who were rude to students and did not make them feel at home. These characteristics fit with the bad staff characteristics identified in the images of students in the present study. It must be said that although the incidence of good and bad staff was not sought, nor could it be calculated, in the present study, the impression gained from students' accounts was not that bad staff were prevalent, as seems to have been the case in the study by Hyland *et al*. The similarity is in the image that can be construed from their accounts.

In a comparison of initial images with experience-mediated images, it is noticeable that although the basic concepts of the good nurse and good (*vs* bad) staff are clearly related, there was only minimal similarity in the features mentioned by students. It seemed that their initial picture was an ideal one, whereas their experience-mediated one was strongly influenced by that experience and was therefore very much from a student's perspective.

McPartland *et al*, in a study of eight metropolitan American nursing schools, identified a shift in student nurses' images of the ideal nurse between first and final years.

Freshmen were significantly more likely to describe their ideal nurse without reference to the skills and tasks of the nurse; seniors were significantly more likely to include technical and professional excellence in their descriptions. (1957:48)

The qualities described by freshmen included sympathy, a desire to help people, energy and mental stability. The researchers interpret the image shift as a move from “naïve idealization” to “more informed and presumably more realistic” imagery (1957:54). It was not clear in the present study that this same direction of shift occurred, as interpersonal skills featured in both initial and inside images as being important for the good nurse or good staff. Curiously, such skills did not seem to figure at all in McPartland *et al*'s study, as the only skills they refer to are “technical skills”. In other words, the “work” elements they cite are only technical, while the non-technical elements mentioned are dispositions or personality attributes.

Three decades later, Mackay stated a similar finding from interviews with students nurses.

What is missing from these accounts of the ‘good nurse’ is any reference to expertise or skill. Such an omission points to the continuing influence of the Nightingale emphasis on the character rather than on the skills of nurses. It may also indicate that nurses give less attention to competence than they give to being a ‘nice’ person. (1989:153)

The same curious feature seems to exist in her interpretation as in McPartland *et al*'s study. Although she offers quotes in which students imply the use of interpersonal skills and expertise, and although she says herself that “learners said a good nurse should be intelligent, confident, and with what might be called good interpersonal skills” (Mackay 1989:152), she seems to count these as “character” rather than “expertise or skill”. In the present study, it makes sense to view interpersonal skills as central to the students’ images of the good nurse/staff, given the prominence accorded to getting involved, as is discussed later.

STUDENTS’ IMAGES OF WHAT NURSING ENTAILS

Most elements of this theme that had emerged from initial interviews were identifiable in the data from the later interviews as well. Their form in the students’ experience-mediated images sometimes indicated affirmation of initial images and sometimes indicated changes in the images.

The Nature of the Work

As the students spoke about their ideas of nursing now that they were participants, it was clear that both physical and emotional or psychological elements were present in their perceptions. A number of them discovered aspects of the nurse's work that they had had no idea existed, and for some this was in accord with the presence of unknown or mystery elements in their initial images.

Many students commented on the busy-ness they had encountered in clinical areas, and this fitted with their initial images. In addition, many of the jobs or tasks they had pictured nurses doing were still part of the picture, though this depended on the type of nursing area they were referring to. In second interviews, those that had not yet worked in medical or surgical wards tended to retain their naïve initial images of what the work of a nurse would be. Valerie and Julie, for example, both referred to their own field, mental handicap, as not being real nursing, and their initial images were retained virtually intact at the time of their second interviews. By their third interviews, they were reporting that their images of what real (i.e. general) nursing entailed were reinforced by their medical and surgical experiences. Julie saw medical nursing as being typical nursing work, with its "bed baths and general care", but the epitome, she said, was what went on in Accident and Emergency, in particular the "bandages, dressings and injections" (3).

Carol, who had had her general modules first, gave an account that contained a number of contradictions. She said she saw medical and surgical as typical nursing work, and referred particularly to "bed baths, dressings and things," as Julie had. She also said it was typical because of the variety, "like on a receiving day you can get so many different things in." However, she also said:

C - Geriatrics is typical nursin', because I mean, you know what you're goin' to do the whole thirteen weeks after your first day. (3)

Thus she seemed to be characterizing her image of nursing as both varied and routine. She differentiated the work in psychiatry from typical nursing, but here again her account was contradictory. At one point, she said of psychiatric nursing that it was "nae nursin' as such, it's more communication." At another point she said, "Communication is very important here [in psychiatry], and I think that's what nursin's all about" (3). So she seemed to be saying on one hand that nursing is not communication, and on the other hand that that is precisely what it is.

Other students also mentioned communication in their inside images, either as not being present to the extent they had pictured, or as occupying a prominent position in the picture. Frances described her picture in her second module as "a communication picture, of a nurse and a patient on the same level, eye contact."

Tina spent her first two modules in general wards, and she stated in her second interview that her experience did not fit her initial image, though an inspection of the transcripts reveals elements that did fit. It seemed to be the misfit of unanticipated negative aspects or absence of anticipated positive aspects that stood out in her perception, whereas the aspects that fit, including those that were negative, she did not recognize as fitting. She had suggested in her first interview, for example, that there would be a class system in the ward, with arrogant doctors calling the tune and not communicating effectively with patients or nursing staff. This she found to be the case, but what did not fit, she said, was

T - the way you have to do everything within a set time, like a shift, and everything's routine and you've got to do it in a certain time and if you don't do it you're in trouble and you don't have an awful lot of time to speak to the patients and things like that. (2)

Although in her initial picture, nurses had been "rushing about" doing "lots of things", communication formed an important part of their activities, and this she was not finding in her experience of reality. As Carol did, Tina hints at the routine-ness of nursing and the lack of variety. Other students, too, commented on this. Helen found that in nursing, "you just do the same thing all the time" (2). This was not what she had pictured, and it was a disappointment to her.

Becky had a different change in her image in regard to a general view of the nurse's work. She had first pictured nurses "doing what patients want done for them," but in her inside image, she saw them encouraging patients to do for themselves. Something in Rachel's new image that did not fit either with her initial image or her reasons for entering nursing was the role of the qualified staff. She now pictured them as organizers or managers rather than carers, and "so far away from the patients" (3).

Malcolm had added a few elements to his image by his second interview, some of which he thought put other people off the idea of doing nursing. These included "cleanin' bums", taking orders from women, and low pay. However, his image of what nursing entailed also included that it was not boring, not sitting in an office, but caring for people.

Thus the students' inside images of what nursing entails were fairly mixed, not just between students, but within some individual students' accounts. Elements of their initial images were still present, sometimes even when contradictory elements were also present, and there seemed to be complications arising from the various types of nursing contexts they had encountered. These constituted differentiation of the image in some cases, while in other cases they seemed to lead to confusion.

The Good and the Bad

The two sub-themes “satisfactions and rewards: the good” and “difficulties and unpleasantness: the bad”, identified from initial interview data, both remained present in the later interviews, though their elements underwent changes. In the later interviews it became evident that these two sub-themes taken together could be seen as an overall organizing theme underpinning students’ accounts of their images of nursing. An inspection of the other sections of this chapter reveals that the notion of a good and bad side to the themes and their properties can be identified throughout. That is, students tended to describe their experience-mediated perceptions in terms of the good and the bad. There are good and bad staff, good and bad features of being a student and becoming a nurse, good and bad aspects of getting involved, and so on.

A number of aspects of the good and the bad remained the same as in initial interview data. For example, students initially believed that nurses would find it rewarding to see patients improve, and this was indeed a satisfying experience for them when it occurred. Their pictures in this regard became more differentiated, however, and they expressed satisfaction from seeing a variety of types of improvement. Donna described an instance from her medical experience of seeing a patient’s physical improvement.

- D - This was the first time I’d seen him walk, and I was delighted, you know? I wouldn’t have thought I would have got that way, you know, I was really chuffed to bits that he’d done this [laughs]. (3)

Frances described it in relation to a surgical ward.

- F - I really like seein’ people losin’ all their bits and pieces, their drains and their stitches, their drips and that, I really like seein’ them comin’ up from lyin’ there practically unconscious to walkin’ about the ward on their own. (3)

Valerie said that one thing that gave her pleasure in mental handicap nursing was “if they start to do things, let’s say like tryin’ to make themselves more independent” (2).

For Angela, an element of unexpectedness contributed to the satisfaction of seeing patients improve. She said that seeing improvement that wasn’t a foregone conclusion was the most rewarding, and in her second interview she illustrated this in relation to the amount of satisfaction of seeing a patient improve after surgery as compared with that of seeing a stroke patient achieve recovery.

- A - I don’t know if it’s as satisfying as seeing it in the long term like that, because you’re expectin’ it, you know, you’re expectin’ the recovery quicker. (2)

In her third interview, she gave the example of having seen a severely depressed psychiatric patient who demonstrated marked improvement following electroconvulsive therapy (ECT), which was unexpected to her as she had never seen it before and had in fact expected ECT to be “barbaric” (3).

The above are just a few examples from among numerous comments expressing students' satisfaction at seeing patients improve. As initially pictured, they also found it rewarding to feel that they had helped to bring about patients' improvement. As Donna said,

- D - Seein' somebody get better (...) there's nothing to compare to seein' that. And knowin' that you've been a part of it, knowing that you've contributed to that man gettin' better. (3)

Malcolm gave an example of a related type of satisfaction.

- M - I really enjoyed if there was a kid especially that came in and was really up tight, and they weren't settlin' down and that, if I could get them settled, you know, if I could speak to them and they would relax, that was really good. (2)

Tina implied the satisfaction of helping people improve by describing its absence, when speaking about her psychiatric experience as compared with her general experience. She said that she could not feel she had had a part in the patients' getting better in psychiatry, as she could in a general area.

- T - In a psych ward, you can see them get better, but you've played only a tiny part in it. It's more themselves, and they'll come better with the medication. I don't feel as though I've done anything for any patients since I came here. (3)

A corollary of the satisfactions of seeing and playing a part in patients' improvement was the reward of being able to see patients and their care through from the beginning to the end of their hospital stay. Eileen put it in a nutshell:

- E - Seeing someone who came in on a trolley walkin' out the door. (2)

In relation to the types of nursing that lead to such satisfaction, the accounts of the students do not altogether agree with the findings of a study reported by Parkes. She indicates that important differences were attributable to the social climates of different wards, and that these were more favourable in surgical than in medical wards. In addition, she suggests that surgical nursing was more satisfying than medical nursing.

In a surgical ward (...) a nurse has more opportunity to contribute actively to a patient's recovery, and is more likely to experience the satisfaction of seeing a patient return home restored to health after a relatively short stay in hospital.

In contrast, a nurse in a medical ward is more likely to care for a patient for a longer period of time, to see a little improvement, and to experience the death of a patient in the ward rather than a return home. (1980:116)

In the present study, while some students did view surgical nursing as more satisfying than medical, this was by no means a commonly held view. As their accounts have shown, for some students, satisfaction did not depend on speedy or full improvement.

SCRIPT

Students had also imagined that being thanked would be satisfying for the nurse, and this, too, was affirmed in their inside images. Gail's account indicated this.

- G - It's nice if people say thank you for things, you know, you feel as though you've actually done them ... even though it's just a small thing that you've done, you feel as though you've achieved something. (2)

She reiterated this in her last interview, and again implied that it need not be for anything very grand.

- G - ... like just something small that was nothin' really, but they'd say thank you for it, you know? I really like that. (3)

It seemed that being thanked was evidence of the nurse's success, and this brought satisfaction. Donna described such satisfaction occurring when she cared for a patient who had had a stroke.

- D - He could hardly speak when he first came in, and he was really depressed, and we nursed him through it, and just before I left, he was goin' home two weeks after that, and so I went back to see him the week that he was goin' back, and he'd bought me this eye shadow kit and things, and it felt so nice, you know, he was such a nice man. (3)

Sarah suggested another version of thanks, namely that expressed by the trained staff.

- S - Whenever you're finishin', if whoever's been in charge of that shift says, "Oh well, thanks for working today," I think that makes you feel good, cause you feel appreciated. (3)

Mackay found thanks to be appreciated by the students in her study as well.

The learners know they work hard but they seem to receive little praise. When praise is given, it stands out above all else, knowing that their contribution is valued. (1989:23)

Related to getting overt thanks was the satisfaction students perceived from the evidence of patients showing them affection. This was expressed by Lorna and Pat.

- L - In [children's ward] seeing them goin' out well, and happy. And here [children's mental handicap] just seein' them laughing, just bein' happy, and comin' over to you and you get cuddles and bozies [hugs] and everythin'. (2)
- P - The thing I found most satisfaction from was one of the kids coming up and giving me a spontaneous hug. (3)

In Helen's case, this aspect enhanced her enjoyment of her mental handicap module; as she put it, "Here you get more love back from the kids" (2).

Students tended to recount such demonstration of affection primarily in relation to caring for children, either sick children or mentally handicapped children. The

analogous picture with adults seemed to be the satisfaction of being noticed and remembered by patients or their families at subsequent encounters.

K - There's a chap up on the surgical ward at the moment, and he was in when I first started there (...) and he's back again to get [temporary colostomy] sewn up again (...) and he remembers me from the first time, and it's quite good, that. I'm quite pleased that he remembers me, cause I mean, it sort of shows that you ... it makes you feel as though you're doing something worthwhile, not just them taking you for granted. (2)

Mary Ann gave an account of being remembered and acknowledged by a relative.

MA - I met one of them in the lifts one day (...) and tap on my shoulder and here's this man, he came in to visit his wife practically twice a day and everythin', she was a long term stroke, and I actually did a project on her, so he came up and asked me how I got on wi' the project and a'thing, cause I asked the woman, and it was like I thought it would be just as well to ask her husband cause she didna really maybe comprehend, so eh, oh he was chuffed, cause I got a good mark for it and a'thing, he was giein' me a hug and sayin', "Oh we'll have the blue pips on you yet," and a'thing, it was really sweet to see him again. It was really good, I enjoyed that. (2)

For some students the nature of the practical work they were doing came to form part of the good in their experience-mediated images. Helen found surgical nursing satisfying because of the opportunity it gave her to gain satisfaction in organizing her work effectively and in doing jobs such as changing dressings and removing stitches. This, however, was a less commonly suggested form of the good than the interpersonal elements. Some students indicated that it was simply the communication itself that gave them the most satisfaction, as Mary Ann said:

MA - Just the conversation and that, really, just the bein' wi' folk, and seeing' them gettin' better, but even when you're nae gonna see improvement in a geriatric ward, still there's just, I like dealin' wi' folk, and the sorta feedback that you get back fae them. (3)

Again Mackay offered a similar view based on interviews with students in her study, along with a comment on the consequences of the lack of such satisfaction.

The importance of patient contact for the learners should not be underrated. The aspect which learners like best about nursing is contact with the patients. Helping, talking, joking, and just looking after the patients is THE *raison d'être* of learner nurses. (...) There is a great deal of dissatisfaction with the lack of patient contact. Such dissatisfaction has both immediate and longer-term implications. Immediate, in that learners don't enjoy the job as much when one of their main sources of feedback is denied them. The longer-term implication is that nursing, as it is experienced on a day-to-day basis, does not meet these learners' needs. They then leave nursing for a more rewarding job. (1989:26)

In the present study, there was no evidence that the students themselves were experiencing lack of patient contact, though this was an element of their inside images in relation to the work of qualified staff.

Students had pictured satisfaction arising from the nurse's feeling that she had done a good job and that she had done something worthwhile. This also came up in later interviews and proved to be a rewarding element of nursing work for students. They found that they could "get a great deal of satisfaction out of giving everybody really good care" (Wendy 3). As Rachel said, "I need to feel as if I've achieved something, done something for somebody else before I get any satisfaction" (2). It seems that their experience had given them an image of nursing that was more positive in this regard than was found by Menzies.

Although the nursing service has considerable success in nursing patients, the individual nurse has little direct experience of success. Success and satisfaction are dissipated... (...) The nurse misses the reassurance of seeing a patient get better in a way she can easily connect with her own efforts. (1960:31)

One could speculate that this represents the effects of the change in the style of patient care delivery from a task-based model to a patient-centred model, whereby it is now more possible for students to see the results of their own efforts.

Interestingly, students sometimes found that they gained satisfaction from something they had initially pictured as an example of the bad. The prime example of this was caring for dying patients. A number of students had indicated in their first interviews that they pictured the worst and most difficult thing about nursing to be dealing with death. However, when they encountered the experience, they found that some of the elements they had cited as part of what they pictured as good in nursing came into play. They could feel that they had done a good job, that they had helped to bring about improvement in the form of increased comfort, and that they could receive appreciation from patients and family for their efforts.

With regard to the bad, again there were elements of students' initial images that fitted with their experience of reality and elements that did not. One type of bad that virtually disappeared as such once it was experienced was the dreaded task, most notably giving injections. Becky's account illustrates this.

B - Givin' my first injection (...) wasn't nearly as bad as I expected, and now you just do them, and afterwards you think, "Oh!", you know, you just dinna really, you just dinna think about it now. (3)

A number of students offered graphic accounts of their first experience of giving injections, but tended to laugh about it. Some now even enjoyed giving them, especially if they felt their skill in the task was good. Becky had indicated in both her first and

second interviews that she dreaded injections, and she was asked about this in her third interview.

B - Oh, that's been no problem. [laughs] Can you believe it, I'm almost enjoyin' it.

AK - Do you remember your first one?

W - Yes, very much, because the staff nurse said to me, "Now don't tell the lady it's your first injection," I says oh no, I wasn't going to, and it was a young patient, she was really quite a good laugh, and she said, "Have you done injections before?", and I said, "Oh heaps and heaps," and she goes, "Oh that's fine," and then after I did it, I said, "Was it sore?", and she said, "No it was fine," I says, "Well that was my first one," and she went "Hhaaa! Oh no!" [laughs] But it was good. (3)

In Pat's case, her first injection didn't go particularly well, but nonetheless that dread was no longer present in her experience-mediated image.

P - My hand shook so much drawing the thing up, and I made a complete muck-up of giving it, you know, sorta the first thing, because the plastic bums you get to practice on at college (...) you need hardly any pressure to get the needle in. (...) And I had to go and change the needle.

AK - What happened to the first one?

P - It just stopped!

AK - Once you'd done your first one, did that pass?

P - Oh yes. Yeah, now it doesn't bother me. (3)

It seemed that by third interviews, injections no longer occupied a place in the bad segment of the students' experience-mediated images, but were still in the picture. They were pictured among the tasks the nurse does, and they also seemed to have become part of the stuff of which memorable stories of training experiences were made.

On a larger scale, the dreaded tasks of caring for the dying and dealing with dead bodies also provided descriptive and emotion-charged accounts of well-remembered patients and experiences. For some students, these elements remained part of the bad in their images, while for others they came to occupy a different segment of the picture, as was mentioned above. This sub-theme is specifically discussed later in this chapter.

One feature of the bad as some students had pictured it that was borne out by experience was the frustration of inadequate staffing combined with an excessive burden of work. One reason this proved to be particularly difficult for them was that it left them feeling they had not given good care. Malcolm and Eileen both described this in their second interviews.

M - One of the most frustratin' things was when you had to rush things. When you didn't really do things to the best that you could, like if you were rushin' around. (2)

- E - We're so busy you feel you can't give your full nursing care and you go home sayin', "Oh no, I know I should've done that. I just didn't have the time." And then if that person dies you think, "Oh no, there's so many things I should've done for them that I could've if I'd had more time." (2)

This inability to feel they had given good care seemed to represent a conflict with the values they held. W.B. Glaser, in a cross national comparison, has observed that

...the problems of a self-conscious and organised occupation arise from the members' and leaders' feeling that they have failed to realize prized values. (1966:1)

He says further that

...in most (or all) countries, according to many questionnaire surveys of students, nursing tends to attract girls with humanitarian motives and with idealized misconceptions about nursing work. (1966:34)

This, he suggests, leads to dropout. His view on this begs the question of whether students' idealized images about nursing work actually are, or should be, misconceptions. As numerous accounts quoted in the present study have indicated, these students had had many experiences of having their values and humanitarian motives realized through the nursing work they had encountered. Perhaps when lack of congruence exists this should not be too readily dismissed as a problem of students' idealized misconceptions, but might more constructively be viewed as a correctable problem within nursing.

Many students had said during their first interviews that part of the bad in nursing would be distasteful jobs, but most insisted that such jobs would not bother them, though they might put other people off nursing. Again in later interviews, students often mentioned such jobs, and most indicated that they did not find them a problem. Helen, for example, laughingly said of them in her second interview, "I just don't care any more, it's just a part o' life now." Hughes suggested a rationale for this.

I have a notion that a task that is "dirty work" can be more easily endured when it is part of a good role, a role that is full of rewards to one's self. (1951:295)

However, students sometimes found certain unpleasant tasks difficult. This included Helen, who had discovered that she "hated doing enemas, colostomies and things like that"(3). For Donna, it was "urodomes", and her account indicates one of the reasons for such dislike.

- D - I had to put on one of them, and I was mortified. I thought, "This is awful!" It was a pupil nurse that showed me how to do it first, and she just went right in about, and whooshed about, and I sat down and I was totally—, I went home and I'd to tell my mum [laughs], it was awful, but even now, I don't like the things, I think they're horrible. It's not embarrassing, but I think it must be quite sore, cause I mean just ram them on, and there's hair all over the place, and it must be really sore for the man. I mean, sometimes it's got to be done. (3)

Finding patients' discomfort difficult to deal with was one of the features of the bad that related to things students had to observe, as well as to such unpleasant tasks. Kathy, for example, described feeling squeamish while a doctor was "poking about" to get a subclavian line inserted in a patient, and had the same experience while assisting with the insertion of a chest drain (3).

Thus much of the bad in students' inside images related to elements which had existed in their initial images. One property of this sub-theme that altered with experience was the relative importance of its different elements. For example, as has already been mentioned, dreads tended to decrease in importance. The most notable element of the experience-mediated bad that came as a surprise to students, and acquired a higher profile in their images, was the degree to which staff constituted the most difficult features of nursing that some had had to cope with. This has been dealt with in a previous section and is not discussed in detail here, but it is important to highlight it in this context because of its importance in the students' experience-mediated images. For a number of students, it was their first answer when asked in a later interview, "What is the most difficult thing about nursing so far for you?" In initial interviews, only the briefest mention had been given, and by very few students, of the possibility that interpersonal relations with staff could be a difficult part of nursing. Thus not only was this element seriously bad, it was largely unanticipated. Staff (good or bad) apparently became the largest single factor in determining the value of a clinical experience for students, with regard to their learning, their enjoyment, and their feelings of self worth.

Mackay's findings seem to offer equivocal agreement as to the importance of staff as part of the bad in nursing. At one point she states:

When learners were asked what was the aspect they least liked about nursing, they tended to focus on particular tasks. (1989:32)

However, at another point she indicates that the students in her study did indeed share the views of the students in the present study.

Bitchiness is THE aspect which learners loathe above all else. When the students and the pupils are asked about their moans after a bad day, it is problems with other staff which overwhelmingly predominates. (1989:96)

Among the students in the present study, this theme again contains evidence that supports the notion of the difference between the outsider's perspective and the perspective of the inside participant. Although students pictured staff in their initial images, it was from a vantage point of looking in on nursing, and they tended to see them as spectators might. In their experience-mediated images, they perceived staff

from the inside, and their images now incorporated an element of the impact staff had upon their own experiences.

Getting Involved

During the later interviews, all the students' accounts included something about relationships they had established with patients and families. When asked about the high points of their experience of nursing thus far, most of them told of involvements with particular patients, and many of these tales were emotionally charged. Most of the students also indicated how they coped with involvement themselves, and expressed views as to how nurses *should* act in relation to getting or not getting involved. Thus their inside images contained, as part of what nursing entails, notions of the nurse's subjective experience of involvement and the ideal model the nurse should emulate.

Some types of attachment had been anticipated by students in their initial images, while other times they seemed surprised at some of their feelings of involvement. Lorna, for example, had expected to feel attached to children, and this was borne out by her experience. She described an instance of this with "this one little boy I really really liked (...), he was just lovely" (2). However, she also found that she got attached to adults.

L - You do, it's funny, aye. (...) It's mostly the amputees, cause they're here for so long (...) and you get to know them. (...) And then there's the sort of person, you know, sometimes you just click with somebody, same personality and that, you know, you can get to know them. (3)

Other students, too, found that involvement was a particular feature of caring for longer term patients. They also found that this could be a source of pain when a patient had a poor prognosis. For Becky this was especially true in psychogeriatrics, where she became attached both to patients and to their families. She found it sad to see patients' wives "go out after their visits just really breakin' their hearts" over the hopelessness of their husbands' dementia (2).

In addition to becoming attached to old people, who seemed to bring forth feelings similar to those they might feel for grandparents, students also described attachments they developed to young people, with whom they had feelings of identification. Kathy, for example, who was a graduate, was particularly affected by a young male graduate who was a patient in psychiatry.

K - I keep putting myself in his shoes, you know, I think, my goodness, I suppose it could happen to anybody. (3)

Students expressed diverse views as to whether getting involved was the right or wrong thing to do. These views ranged from the notion that one couldn't be a good

nurse without getting involved, to the notion that getting involved should be avoided at all times, either because it is unprofessional or because it is too costly for the nurse. In between these extremes were views such as: getting involved is acceptable, as long as it doesn't lead to favouritism; getting involved is not good, but it is impossible to avoid when the nurse works so closely with people; getting involved is acceptable but painful, so the nurse has to balance the amount of involvement, for her own sake; and nurses inevitably become tougher as they learn to protect themselves from the personal cost of involvement, but this makes them poorer nurses. Thus this element of the students' inside images was as inconsistent as it had been in their initial images.

In many cases, individual students' views in this regard were ambiguous. Some did not appear to perceive the ambiguity. Gail, for example, said:

G - I don't think you'd be bein' a proper nurse if you actually got so attached to a patient that you went home and cried. (2)

But she also said:

G - I'm sure you would sorta cry if it was like a young person, just, you know, like a waste of a life, you know, somethin' like that. (2)

Carol, on the other hand, did seem to perceive the quandary.

C - I get too involved. (...) You've got to draw the line somewhere, but where do you draw the line, this is it, and you begin to think, well, where div ye? (3)

Oliver was atypical of the group in that he expressed the view that controlling the amount of involvement was perfectly within the nurse's own power. "You can become as involved as you want to, so it's up to yourself, really" (2). His opinion did not appear to have altered by the time of his third interview, when he said of his encounters with dying patients, "It's not something that concerns me, really" (3).

There seemed to be a commonly held belief as to the received wisdom on the subject of involvement, namely that it shouldn't happen. This was commented on by Menzies.

A necessary psychological task for the entrant into any profession that works with people is the development of adequate professional detachment. (1960:13)

A curious feature of the accounts of students in the present study was that none could specifically state where this guidance had come from or name any individual who had articulated it. Tina, for example, said:

T - Although they say you shouldn't get attached to patients, I don't think how anybody could not get attached to some patients. (3)

However, she could not identify who “they” were who said “you shouldn’t get attached”. Malcolm similarly said:

M - There’s some folk say nurses shouldn’t get involved because it’s not right to be involved. (3)

He, too, couldn’t identify who “some folk” were; the only specific person he identified who had made a statement on the subject was a tutor who had said the opposite. Carol mentioned the supposed dictum in both her second and third interviews, but when pushed, she, too, was unable to name the source of it.

C - College try and tell you to keep your distance and not get involved, but like one o’ our senior tutors was sayin’ it’s a load o’ rubbish, says everybody has their favourite patients and you do worry about them.

AK - Does somebody actually verbalize to you that you shouldn’t get involved?

C - Aye, they do, they put it that it’s, they don’t say it outright, but they put it gently round that you’re not supposed to get too involved. (3)

The students’ personal accounts of their own cases of involvement were interesting, and often affecting for the interviewer as well as for themselves. Some of the attachments seemed to have been motivated by the attraction of the individual patients or residents or their families, while some were more related to the situation the patients and families were in. Lorna, as mentioned earlier, cared for a little boy she just “really really liked, he was just lovely” (2). There was nothing particularly tragic or special about the little boy’s case, she just liked him. By contrast, Frances (a mature student) found herself drawn to people that other people rejected. She offered a tentative reason for this: “I think I’m mothering them” (2).

Yvonne offered an example of a rewarding relationship, but again with an undercurrent of feeling that she was breaking the rules. She cared for a patient who became “like a friend as well.”

Y - I actually visited her, when I was on holiday with my sister and my friend, and we went to [town], that’s where she was, she was absolutely over the moon, I mean, she’s only young as well ... and she really appreciated it, cause she’s nae actually from [town], she’s from here. (...) I know you’re nae meant to do that. (3)

Thus Yvonne’s feeling of gratification seemed to be tinged with guilt.

Rachel retailed an experience of having developed strong feelings about a patient, seemingly related to her own feelings of responsibility. He had carcinoma of the lung, and “for three days he was really quite poorly, and I nursed him all the time.” He then had a stroke, she said.

R - I sorta blamed myself, because he’d been my patient the day he’d taken the stroke, and I thought, “Should I have noticed something?” (2)

Oddly enough, Rachel's account of this, and of his ensuing death, was offered in response to a prompt asking about what was satisfying about nursing.

Another type of fraught experience with getting involved was exemplified by Eileen's account of caring for a woman with a terminal illness. The pain of the involvement resulted not so much from the fact of the woman's diagnosis as from the fact that it was concealed from her.

- E - We got on really well, and then she'd been told she'd got cancer, and she thought I had deceived her, and she called me a bitch and all the rest of it, and I just, oh!! (...) She thought whatever I had was pity for her, and she just didn't speak to me for ages, and then she died, so that was a bit upsettin'. (...) She was such a nice b'dy, and then she thought everyone had been against her. And she had so little time to live anyway, her poor son as well, he got the same treatment. (...) I felt they should tell her, but I didn't really feel it was my prerogative. (2)

Thus the pain of this experience seemed to be tied up with questions of communication, truth-telling, and the student's feeling of powerlessness.

Some of the students' accounts of the pain of involvement were also accounts of its rewards. Perhaps the most powerful example of this was offered by Carol during her second interview. Her first ward had been a particularly difficult one, in terms of the type of nursing. It was known to be one where cardiac arrests were frequent, and she had described herself during her first interview as being terrified of going there to work. However, she said she found the staff to be outstanding, and in the end enjoyed the experience thoroughly, though she also found it draining. She told the story of her experience with one particular patient who was admitted on a day of many cardiac arrests.

- C - He was just a wee tiny man, he just lay in this big bed and he looked so small, and he was really really skinny, there was just nothing o' him (...) and he was so weak he couldna hold his cup or anything, so I was holdin' his cup, I give him a straw and he was drinkin' his milk, and his son came in, and I suppose it must have been a shock to his son seein' him in this big bed lookin' so ill, and he started cryin', but he was tryin' not to let his father see him, that he was cryin', and I was givin' this wee mannie his drink of milk, and he says "Thank you, nurse," and he gave me a big kiss, and I went through the back and I cried. (...) And the only care we could give him was lovin' care, there was just nothin' else we could do for him. (...) But that was really, I was the first person he'd spoken to in two months, oh, it was really, god it was ... oohh! But that's what it's all about.

AK - (...) Was that in some way a rewarding experience for you?

- C - Yes, it was, aye, it was really, oh ... the air was full of just electric, it was ... oh, I don't know, it was hard to describe, well, it just makes you think, "Well, this is what I'm here for." (2)

By the middle of this account, Carol was in tears (as was the interviewer), and when it was recalled in her third interview, some nine months later, it still made her cry, while

laughing at herself for doing so. Two comments imbedded within the account seem particularly telling: "But that's what it's all about" and "it just makes you think, 'Well, this is what I'm here for'." The implication seems to be that something in the nature of this sort of involvement constitutes the essence of nursing. That is, in Carol's inside image, nursing *is* getting involved.

An interesting sideline to ponder with regard to this last account is that Carol hoped to leave nursing after she had finished her training and staffed for a short time, to go into police work. Given the limitations of the data, the ramifications of this can only be speculated about, but they might suggest a line worth exploring in more detail.

Finally, Donna was another student who seemed to feel herself inevitably drawn to involvement but was aware of the personal cost as well as the reward.

D - I didn't think you would get as involved as you do, but you do (...) you're bound to get involved. And every time somebody dies or that, you really do feel for it, every time, you always feel like you're grievin' a bit yourself, and then the other way, like the stroke patient, you see them comin' in, they're so helpless and so depressed and everything (as in the case of a particular patient) the first time I'd seen him walk, I was delighted, you know?, I wouldn't have thought I would have got that way. (...) You know, I wouldn't have thought so, really, total strangers, you know, but you do, you really feel it. I don't know if it's a good thing or a bad thing. It's a good thing if they get better, you know, but it hurts you a lot if they die and that, it really hurts your feelin's, I mean, I don't know if I can toughen, I don't know if I should toughen up ... (but if you do toughen up) I don't think you can give the care then, cause if you care about somebody, then you do. (3)

Caring *for* seemed to entail caring *about*, to Donna, and her inside image seemed to be in agreement with Carol's that getting involved was the essence of nursing.

The issue of the cost of involvement has been commented on by Thorner, who has stated:

The nurse (...) cannot allow herself to become emotionally involved without paying a penalty... (...) if she were to bring her professional cares home with her, the nurse would collapse under the strain. (1955:534)

Davitz and Davitz, among others, suggest that the personal orientation of students entering training is such that it leads to this problem.

Many young people enter nursing with a strong sense of idealism that is reflected in a kind of universal sympathetic reaction to everyone who is suffering. (1975:1510)

This idealism is "inevitably modified", they state, as the students face the "realities of practice" (1975:1510).

It is not clear in the present study that such idealism was lost in the students' inside images of nursing. Instead it seems from some of the accounts quoted above, and

others of which they are representative, that a noticeable degree of idealism was still present in their experience-mediated images with regard to the notion of getting involved.

As has been implied in a number of the above accounts, some of the most moving experiences of getting involved occurred when students were dealing with death in one way or another.

Dealing with Death

Dealing with death was an element of students' initial images of nursing that had been mentioned in first interviews as dreaded, one of the most difficult things nurses had to cope with. By their third interviews, most of the students had had experience with death. There were several aspects of the experience they spoke of: caring for and communicating with a patient who was dying, coping with cardiac arrest, dealing with a dead body, dealing with the family of the dead person and handling their own responses to a death. Different students had difficulty with different aspects, and a few claimed to have no difficulty at all. Their inside experiences clearly influenced their developing images.

In relation to dying patients, communication posed a major challenge for students. An example of this has already been shown in Eileen's account of getting involved. Frances gave a useful account that illustrated various aspects of the discomfort.

- F - The most difficult element is dealing with a patient who you know knows that they have no chance, and you go through to them, and you only just found out that they've known for a while, and you think how bright and breezy you've been to them and what a fool you've been really. But then you didn't know. And what do you say to them? Do you say anything about their situation, or what? (3)

She was not asking for answers to these questions, but merely expressing the quandary she perceived the novice nurse to be in. This feature of the students' inside images has obvious links with what Melia has referred to as students' experiences of "nursing in the dark".

The students' main complaint (about communication) was that they are often left short of information, or as some of them put it, 'in the dark' about patients' diagnoses. This information lack means that student nurses find it easier not to talk with patients beyond a superficial level rather than fumble their way in the uncertainty which lack of communication produces. (1983b:62)

Frances's example moves on to the next stage, when the student's ignorance is dispelled and she has to cope with her perception of the triviality of her previous

conversations with a patient who had much weightier concerns which she had inadvertently appeared uncaring about.

Malcolm acknowledged the difficulty of communicating with dying patients, but also had a view beyond that.

- M - You've just got to go through and say well, I'm gonna do my best, and just try and keep this guy happy or whatever, for his last few weeks, cause I can see nothin' worse than that folk who are just left in their last couple o' weeks and folk don't go near them because, "What will I say to them, they're goin' to die?" (3)

He went on to give an example from his own experience.

- M - I remember the first time I was really agitated about goin' to somebody was in [children's ward] when there was one lassie came in, she was all right, and then found out she'd a tumour on her arm, she had to get her arm taken off, and she had chemotherapy, and they were told she wouldna last probably more than a year anyway, you know, and from speaking to her beforehand, and then suddenly, she's got her arm off, and she's depressed and all that, and I'm standin' there, and I really, you know, goin' round, doin' anythin' with her, I started feelin', you know, my stomach started churnin' and I thought, "My god, what can I possibly say? If I say the wrong word, will she burst into tears?" I did get a bit, for a start, but then her folks were goin' in, and they started speakin' to us, and I started goin' in to speak, and really she was fine. You imagine more barriers than there is, because they really are needin' company, there's no special magic thing, I think for a start you feel that there must be somethin' that you have to know, one particular thing that you can't possibly know about until afterwards that you've got to do to keep these folk happy, but they're just the same. (3)

Malcolm's account offers a description of the transition between his initial image and his experience-mediated image in this regard, and clearly demonstrates the move from the outsider's to the insider's perceptions. It is congruent with a further finding of Melia's that among the students in her study, the reality may have been less dramatic than their pre-experience images.

The students gave the impression that lack of information caused, in the main, irritating day-to-day problems, yet when they gave an example it was invariably a dramatic one of diagnosis disclosure. It might be argued that this kind of dramatic event occurs more frequently in the students' imagination and anticipation of problems than in their actual experiences. (1983b:63)

Sometimes communication with dying patients was a rewarding experience for students, particularly if they felt they had done something to ease the patient's mind in his last days or hours. Ian described a feeling of satisfaction at having developed his skill in communicating to the point where he could speak effectively with a dying patient (2). This seemed to him to be a significant goal to have reached.

Physical care was also important, as it constituted another way in which students could improve the dying person's quality of life for the time that remained. Valerie, for example, found caring for a dying patient more satisfying than stressful.

- V - I wouldn't say it was stressful. (...) I'd say in a way it is satisfyin', because you're sorta tryin' to do more for them to make them comfortable, to make sure that their last days are good days. (3)

Cardiac arrest was a worry to some students because of their concern over whether they would respond to it correctly or not. Pat described this from the vantage point of having been an observer/helper without having taken part in the resuscitation.

- P - I've experienced the panic of having to set up for it, and run and get all the stuff, but I haven't actually participated in one. (...) Unfortunately the person was dead on arrival. But then the first real one I saw, they managed to revive. It sorta compensates. (3)

When a patient was not successfully resuscitated, students seemed to find the suddenness of the death difficult, especially if it occurred to a patient they already knew.

Yvonne described the unexpected death of a patient in her surgical ward.

- Y - He was goin' home that mornin', and durin' the report he just went, like that. He'd nae even had an operation.

AK - And did you know him?

- Y - Yes, it was awful. He was ready to go home, terrible. (3)

For most students, the first death they experienced had a special significance. It seemed to be particularly poignant if it had a resonance with something in their personal lives. For Lorna, the first death she encountered was that of a man who reminded her of her grandfather, who had died a year before. It had been sad, she said, but it was a release for him because of his condition, which was similar to her Grandad's.

- L - It wasn't as bad as what I thought it would be, no, I could accept it, because I could see the similarities between my Grandad and him. (3)

If the first death that occurred was not a patient the student had known, it might be a later death that took on more significance. Yvonne found this to be the case, saying, "The second one, I'd known her, it was mair sore than the first"(2).

Often it was the first experience of dealing with a dead body that students found trying. Angela found this with the first death she encountered.

- A - It was the last offices that upset me most. It's difficult to describe, you know, but you just kinda feel a lump in your throat or something, y'know't I mean? (3)

Helen found that she had to sit down when she saw her first dead body. The patient wasn't one she had known, it was just the idea that it was a dead body "just lyin' there" (3).

As with dying patients, some students found that the impact of seeing a body could be influenced by personal experiences, as it was for Carol.

C - It was really horrible, cause that was the first body that I'd ever done, and well, it's just a year ago my Granda died, and I kept thinkin' about that, and I was shakin', it was just, I don't know, and seein' his face, his expression on his face, oh it was horrible. (2)

The stress of this experience was somewhat alleviated by the support of a sympathetic staff nurse at the time, but nonetheless Carol said she had cried after she went home.

For Natalie, the first body she observed was of a previously healthy toddler who had died of meningitis. She found the idea of such a child's death "terrible", but she was not bothered by the sight of the body, and she attributed this to the fact that she had not nursed him (2).

Rachel had an uncomfortable experience of a different sort related to "doing a body". It was a patient she had cared for for several days...

R - ... and then he died, and all I wanted to do was do his body, but nobody asked me did I want to do his body. (...) I wanted to do his body, because I felt that was the very last thing I could do for him, and I felt it was my, as if I had the right to do it, and if I'd done that I think that would have been very satisfying. (3)

An interesting feature of this account is the notion that "doing a body" can be a source of satisfaction, one which in this case Rachel felt she should have been entitled to.

Dealing with families after a death could be a challenge to students. Sometimes the difficulty was simply with their feelings about the family, as when Carol commented that "seeing their relatives coming in is really heart breaking" (2), and Natalie said "mostly it's the relatives that get to you" (3). Julie referred to this in relation to sudden death encountered in Accident and Emergency.

J - It's not so much the person who's died you think of when there's an arrest like that, it's more relatives, it's so totally unexpected, and it can be quite a, you could put yourself in their shoes and think how you would feel, I mean, there was a lady who was 54, that's only a couple o' years older than my mum, you know?, and I thought, well, what if that was Mum? That's when you stop and think, and oh no. But you try not to think about things like that. (3)

In such a case, not knowing the patient meant there was not the same danger of feeling upset at his death, while the suffering of the family, who were visible, was imaginable. In relation to the discussion of students' views on getting or not getting involved, here Julie seems to be indicating where the limits of the nurse's empathy should be set, in her experience-mediated image.

Mary Ann recounted the story of a particularly upsetting experience with a relative. She had answered a call from an elderly patient's wife and had given an account of his condition, and half an hour later the patient had had a cardiac arrest and died.

MA - I thought, oh no, fit'll she think o' me, ken? I mean obviously I couldna knew that he was gan to do that, but I thought, she'll think, oh I was makkin' her think that he was OK and actually he wisna. She came in and I felt like I had to speak tae her, ken, so I went and I gave her her tea and that, and I said, "Well, it was me you spoke to on the phone, I'm sorry, it's probably such a shock to you," and she just says, "To tell you th'honest truth, m'dear, I thought he was gonna go last night, he was so bad," and she says, "You did say that he had a bad night," so I felt a bit better after that. (3)

This account was also an example of an interesting side feature of the interviews. Many of the students were fairly broad-spoken in their natural patterns of speech. Although they tended to use a "proper" accent when the interviews first started, they soon relaxed into their everyday style of speech. However, it was noticeable that some became considerably more broad in their accents and use of words when they became caught up in an account of experiences that had affected them strongly. This was evident in this interview with Mary Ann, that is, her speech was quite broad in general and became noticeably broader as she described the experience quoted above. It was almost as if, for such students, the breadth of their accent served as a barometer of the depth of their feeling about the topic of conversation.

Students showed concern over their own personal response patterns in relation to death. Some had cried and thought they shouldn't, some had cried and thought it was acceptable. Some cried in the ward, some waited and cried at home. Some felt like crying but didn't allow themselves to. Tina had not been able to control her crying response after dealing with the body of a patient she had known well.

T - I was OK once we'd finished it, but then after about ten minutes later, I just burst into tears. I just couldn't cope, cause I was just, you know, you're OK at the time, and then once you think about what you've just done, it's horrible. (2)

She felt she had been fortunate on this occasion, because she had the support of a sympathetic staff nurse and sister.

T - They said don't worry about that, and they took me to the room for a coffee and everything and it was really nice. (2)

Donna gave an account which displayed her perceptions of a multitude of the features mentioned above: the first death, the first cardiac arrest, dealing with relatives, dealing with a body, dealing with her own responses, and the support of staff.

AK - Do you remember the first one?

D - Yeah. Burstin' into tears, it was awful! (...) It was the first cardiac arrest, he came in with, em, what did he come in with?, I think he had an MI, I couldna be a hundred per cent sure, and he came in, cardiac arrest, so the arrest team came up and everythin', standin' peerin' round the curtains, cause I didn't want to go in, and I didn't, everyone was fleelin' around, and I figured that I wanted just to watch, you know?, so I was peerin' around the curtain, all this folk runnin' around and everythin'. Anyway, he didn't, they didn't make it, right?, so me and a staff nurse had to go in and just get him washed and that, and his wife wanted

to see him before he got the shroud and everything on, so we just washed him and packed him up and that, and we put a sheet over him, and his wife went in and em, she was really really upset, when she came out, I says, "Look, have a seat," and the staff nurse went away to get a chair to take her downstairs, you know, her son or somebody was with her as well, and I says, "Come on, stand up and put on your jacket," she stood up and grabbed me by the shoulders, head on my shoulder, burst into tears, tellin' me how much she was gonna miss him and everythin', and I thought, "Oh no!", so I just burst into tears as well, and I'm cryin' on her shoulder and she's cryin' on my shoulder, and Sister, I just felt this hand on my shoulder, "Go to my room," [little laugh], so I went, and she made me a cup o' coffee, and she says, "That's unfortunate," you know, but it really upset me. (...) I sorta waited, I didn't want to make a big thing, so [the wife] sorta says, "Oh, I'm sorry for upsettin' you," and I says [weeping sound], "That's all right."

AK - Did you know the patient quite well?

D - No, I didn't, I only knew him for a few days, but I was really upset, it just, what really got me was the colour, cause he still sorta had blue bits and pale bits, you know, and then what really got me, the terminal work, he made like a gargley noise, you know, and I went, "Oohhh!" I was not prepared for that, you know?, and what a sorta scare I got, and like I was up to high doh doin' this, you know?

AK - You were doing this with a staff nurse, were you?

D - Yeah, she was really good, she was just sorta speakin' away and that, she was really nice, she apologized for not warnin' me and things first, but it was ... So I think I'll remember that. But the thing I think I'll remember most was, there was this man, and he wasn't to be resussed, you know, he was really ill (...) he was quite old and that, and he was a really really nice man, I got to know him really well, you know?, and he was dying, and so Sister says, "Pull the curtains round, and sit in and hold his hand," she says, "and he'll just, he'll die soon," you know, he was Cheyne-Stokin', and I sat there, and it was about three quarters of an hour before the man died, and I stood above him four times in between thinkin' that he'd already died, you know how he'd had a breath, and I sat thinkin', no pulse or nothing, and then he'd go "Hhuhh", so I'd think, "Oh no," but it was so peaceful, just the way he went, and I sat there for a good ten minutes I think, lookin' at him, to see if he was really dead, you know? See he looked really peaceful, and then there was no breath or nothin', and I thought, "Well, he must be away," and I was scared to go out in case he'd take this other breath, you know? But it was really peaceful, it was really nice.

AK - So that wasn't an upsetting sort of death?

D - No, no. The only upset one was the first one. And one [patient with leukæmia], he just had his first granddaughter while he was in, but he couldn't get out to see her for a while, cause his white cells were down, and he was reverse barrier nursed and everything, so when eventually he did get to go, we all made a fuss of him, you know, took him down to the maternity unit, and he was tickled pink, came back, and he got home for a coupla days, and it sorta perked him up, havin' his granddaughter, and then he came back in, and Christmas Eve he died, and the doctors and everyone else were cryin', cause he was such a nice man. He was really, he was so uncomplainin' all the time, and the last time, he was so tickled wi' his granddaughter and everything, his first grandchild, it was such a, it was so sad. (3)

Donna's account seems to demonstrate many of the mixed feelings students indicated in relation to death experiences: the hurt, the sadness, the satisfactions of caring, the feelings of compassion, the contrast between the chaos of a cardiac arrest and the

peacefulness of a quiet death, and throughout it all, the need to cope with her own feelings and responses.

A few students indicated that they had in some sense not dealt with the deaths they had encountered. Becky described not finding her first experience with a body difficult because "I don't suppose it really had sunk in that they had died" (3). In relation to doing last offices for the first time, Valerie, laughing apologetically, said, "I sound a bit heartless, but I didn't really feel anything" (3). Zena described having been upset "for a coupla days" when a patient she had known well died, but then said after that she "left it behind quite easily," adding (also with an apologetic laugh), "Sounds callous!" (2). It seemed that these students felt that somehow they should have been more affected, and had to show me that they recognized that I might think they should have been, though at the same time they were honest about what they actually felt (or didn't feel).

Eileen indicated that she was not dealing with her feelings about death, but that she was aware she was doing that.

- E - I've still, always at the back of my head, I'm not takin' it forward, I'm just shuttin' it away, you know what I mean? In this ward I've had two deaths so far, and I've just got on with last offices and that. I'm tryin' not to think about it. (...) I know fine it's there, one day it's gonna catch up wi' me ... but just now ... (2)

By her next interview (3) she said that with experience she had gradually become more capable of coping with death, and she now wasn't keeping her feelings at a distance; she didn't need to.

Sarah claimed that the deaths she had encountered, of which there had been quite a few, "didn't bother me, not really" (2). However, later in the same interview it became apparent that this was not an accurate assessment of her feelings. For example, in describing her experience with one of the dying patients, she spoke with her voice breaking of feeling "so useless sittin' and knowin' that all I could do was hold his hand" (2). She exposed a further ambiguity in her thinking when she went on to say how useful it was just to be there and hold the hand of someone who was dying.

Julie expressed a difficulty over one particular death, not because of her own responses, but because of some of the responses of other people. The death was that of a young mentally handicapped man.

- J - It was quite a cruel kind of death [road accident]. But I think that's why it upset me so much, cause people say, "Oh he's probably better off dead, cause he's not got anything to look forward to," but everybody's got something to look forward to. (...) He was usually happy, he liked his music, and he was grinnin' away most of the time. And his parents were very close to him, he went home very often. So you felt for them as well, because they will really miss him. (2)

Perhaps the most common view of the students in this study was that death was bound to affect them as nurses, and that they would probably feel low at times, and might cry, but that, as Yvonne put it, "You get on with it"(3), because it should not be allowed to affect your ability to do your work. They were grateful for the efforts of supportive staff who helped them through their early experiences with death and its ramifications.

Links between dealing with death and other components of the students' inside images are obvious. Staff could make or break the students' ability to deal effectively with death-related experiences; learning to deal with death was an integral part of being a student along the road to becoming a nurse; and it was often the type of instance students cited to describe the issues surrounding getting involved.

It was clear that dealing with death continued to occupy a prominent position in the students' inside images, as it had in their initial images, though it had acquired additional dimensions. It retained some of the properties that had made it part of the bad in their initial mental pictures, but for many of them it was discovered to have properties that also made it part of the good. It could be one of the most poignant forms of working with people and helping that they had so far encountered in nursing, and in this sense it formed an important part of what they saw as the essence of nursing, in their images.

OCCUPATIONAL LABELS FOR NURSING

Of all the themes and sub-themes, this one revealed the least about the changes that took place in the students' images of nursing. During second-round interviews it became apparent that discussion of the occupational labels they would assign to nursing elicited data that did not differ substantially from the first-round interview data, in most cases. For this reason the topic only came up in third-round interviews in a few cases.

Most students still preferred to say nursing was not just a job though some were less adamant or idealistic about this than they had been in initial interviews. This often seemed to be related to their feelings about the ward they were in at the time of interview. Eileen had initially said nursing was not a job and preferred to call it a caring profession. She was asked about this in her second interview, during what was for her a difficult clinical experience.

AK - Would you still call it that?

E - I'd probably call it a job.

AK - Why is that?

E - I don't know. Cause I go in there and I think, "Right, I'll be off at half-nine." You know, it's like a nine-to-five job, it's just, you're in there for your time,

and you get on with your work, and then you're ... it's more like, I go in there and I, I don't know, I haven't got the enthusiasm that I had when I first started. Well, not in this ward. (...) I still see it as a profession as well (...) cause you've got that goal of staffie, you know. (2)

The portion of her first interview in which she had differentiated nursing from jobs such as waitressing on the grounds that a waitress was just a skivvy was quoted to her, and her response was:

E - You're just as much a skivvy up there [surgical ward]. You're just a pair of hands. (2)

In her third interview, however, she said, "I would go back to calling it a caring profession"(3). This change was due, she said, to her feelings about the wards she had been working in meantime rather than any overall change in the way she perceived nursing.

All the other students who had said nursing was not just a job in their initial interviews reiterated this in their second interviews, and for much the same reasons. Donna described her view of this .

AK - You said it wasn't just a job—

D - No. I would still say that. There's no way, I mean, if you come here for a whole weekend, or workin' in [another ward], and you work that long hours and you're that tired, there's no way you would do it just for a job. Unsociable hours and all that, you know, all your friends are goin' out and you're workin' till half past nine or somethin'. There's no way you could stick it, if you didn't enjoy it. (2)

Mary Ann's explanation was similar.

MA - If you were wantin' just a job, I don't think you would do it. (...) It has weekends and nights and everythin', it is hard work, sometimes physically, most times mentally, but if it was just a job you were wantin', I dinna think you would, you should do it. (...) If you were just wantin' money or anythin' oot o' it, I dinna think it ... it wouldna be worth it probably, and you wouldn't enjoy it. (2)

Most students implied that their inside images of nursing included that one had to exceptionally motivated in order to tolerate it. As Pat expressed it, "You'd be a total mug to get into nursing if you didn't really want to do it," referring to the mucky work, mediocre pay, unsocial hours and otherwise less-than-ideal working conditions.

Apropos of the motivation required for "not just a job", a number of students indicated that the degree of commitment to nursing had more to do with a student's personal orientation to it as an occupation than to any innate characteristics it possessed. Some spoke of plans to train for a second register, do midwifery or other additional professional preparation, and some spoke of the types of posts they would like when they finished. Some, however, referred to "doing nursing" as if it were something that only lasted for the duration of the period of training. This was implied in a phrase used

by several students when they said, "I'll do my nursing, and then..." For some, the "and then" led to another type of paid employment, such as police work or working for an airline, while others indicated their intention to get married and have family, relegating nursing to a secondary position in their life plans. So it seemed that although they stated that they still pictured nursing as not just a job, some were treating it as such in terms of their future plans.

Carol's account showed the ambiguity of terminology noted in students' initial interviews. That is, she referred to nursing as a job, but not in the sense of selecting that word as the most appropriate occupational designation.

- C - It's like my dad, he says to me, he says, "I don't know why you didn't get a decent job instead of gettin' a job for love instead of money." [laughs] And he says, "I respect you for doin' the job," he says, "but you could have got a job wi' more money, you know." (2)

There was little else revealed about the students' experience-mediated images via discussion of occupational labels. By and large, they seemed to have had their initial images reinforced with regard to what type of occupation nursing was and the properties that characterized it in comparison with other occupations.

Sarah added a comment that did not employ any of the labels.

- S - I think it can be anythin', it can be fun, it can be sad, it can be tirin', I mean, I just think about any adjective I can think of could describe it, and that's how I feel at the moment anyway. And you get your laughs, and you're upset sometimes, and you get attached to patients or to wards and staff, so I think just about anything I can think of would describe it. (3)

Thus she could find many words to describe nursing in her inside image, but no single label that encompassed them all.

BEING A STUDENT – BECOMING A NURSE

This large and diverse theme from the first round of interviews changed shape in the analysis of later interview data. This was inevitable because of the obvious change in the vantage point from which the students were viewing nursing.

Regarding sources of image, the elements revealed in initial interviews did not need exploring further, and the new source, their experience in nursing as students, was obvious and pervaded all the interviews. It is therefore not discussed as a discrete sub-theme.

Choosing a Career: Police work

With regard to most other careers considered, further discussion was not pursued, but the frequency with which police work was mentioned, and the additional view of nursing its discussion offered, made it a useful topic in later interviews.

When the frequency of an interest in nursing co-existing with an interest in police work became evident during the latter interviews of the first round, the theme was explored in subsequent interviews, in one of three ways. It was brought up in later interviews with students who had mentioned it in first interviews but with whom it had not been pursued at the time. Students who had not mentioned it themselves were asked what occupation they would consider if for some reason they could not do nursing. A number offered police work in answer. With those who did not, a third tactic was employed, that is, they were asked if they would ever consider police work.

Of the twenty-four students interviewed in the study, fourteen indicated that they had considered or were considering police work. Valerie had sat the entrance examination but failed it. Pat and Ian had both seriously considered police work but had not grown tall enough. Frances had planned to go into the police when she left school but had decided to get married instead. Carol stated that she intended to go into police work after staffing for a short time. The remainder of the interested students simply said police work was something they had considered or would consider if nursing didn't work out for them. Two of the ten students who would not consider police work themselves said they had a number of student nurse friends who were considering it.

Students were asked whether they imagined that there were similarities between nursing and police work which attracted them to both. Their responses provided an additional view of their images of nursing. Frances gave an array of such characteristics.

- F - It's dealing with people, and some police work is helping people, and being there in stressful situations. Some educate people, like nurses are supposed to do. (...) And the uniforms [laughs], and the shifts. (...) I wouldn't do it now, it's far too violent now. Mind you, you get violence in [her current ward]. (3)

Quite a few students named working with people and helping as characteristics they imagined nursing and police work to have in common. Several specified, as Frances did, that there was something particular about the context in which the helping took place. Kathy described the similarity as "contact with the public in times of distress" (3). To some, an implication of working with the public was, as Carol said, that it meant "not sitting in an office" (3). The fact that people were being helped at a time of crisis or distress was related to the need for good communication skills. Wendy suggested that in both occupations a person needed to be confident and assertive.

Tolerance was also needed, because members of the public often had to be given the benefit of the doubt if they were behaving in an unacceptable manner, because the behaviour might be due to the stress of the unexpected situation they were in, which was unfamiliar to them.

When asked why police work came to mind in this regard instead of, say, social work, physiotherapy, or other health care or service professions, another feature common to nursing and police work was suggested: both have high media profiles, which many other helping professions do not. Malcolm included this in his account.

M - Things like physio, you don't see a lot of, unless you're dealin' a lot with hospitals (...) you don't get the same exposure to it, like on the telly (...) and as well, it's somethin' that's a public service, it's something' pretty demandin', it's caring (...) you would have to deal with things like rapes and that (...) some folk would think (...) with all the TV programmes about police and that would think all this drama and that, and perhaps some of the medical programmes and that show (...) everybody runnin' about, you know, and their masks on [laughs] and you know, life and death every second minute, and I s'pose drama and all that and the excitement sorta thing.

Other students also mentioned the elements of drama and excitement, both in the public images and to a certain extent in the reality of both occupations, as perceived in their inside images.

Heyman *et al*, in a longitudinal study of socialization among a group of nurse trainees, found evidence of the attraction of police work and medically-related work, and identified trends over a time period similar to that covered in the present study.

This work has presented strong evidence that attraction to, identification and congruence with medical roles increases as a result of training, and that attraction to and identification with non-medical low-status roles decreases. (...) The results also suggest that trainees become more attracted to and identified [*sic*] with social roles in general, including teaching and police work, rather than just medical roles. (1983:66-7)

They make no claim to have identified causality related to these changes. In the present study, though the issue was not specifically pursued, there was no impression gained that the students' interest in other professions had altered greatly over time. Even those students who were planning to go into other fields at some point were still interested in the fields that had interested them initially.

A study by Mackay involving interviews with 21 students revealed a picture similar to that found in the present study.

One-third of the learners had considered joining the police. At first glance it seems a curious alternative choice. However, both occupations involve a great deal of contact with the public, have to cope with emergencies, are uniformed and command some respect in the community at large. (1989:32)

In one regard her students differed from those in the present study.

The main attraction of the police was the pay. Pay is a source of great dissatisfaction for learners. (1989:32)

In the present study, pay was not prominent, either as an attraction of police work or as an expressed source of dissatisfaction with nursing, though in general terms low pay appeared occasionally as a well-known element of the nursing image.

One interpretation that can be made in relation to the attraction of police work, and that fits with components of other themes, involves the notion of belonging. A person who belongs to nursing or the police, and wears appropriate uniform denoting that fact, is in a special position. Only such persons can answer the specific need; they can be assumed to have the required skills and qualities and they have the right to have their role status in that regard recognized.

The discussions of police work highlighted several characteristics in students' experience-mediated images. They now pictured nursing as not just working with people or the public, but doing so at times of distress. It was a recognized occupation with a high media profile, commonly believed to involve drama, a belief they now imagined to contain a degree of truth. Finally, the notion of belonging was reinforced.

Being a Student 1: Living with the Requirements

In the initial interviews, students gave accounts of factors that made them choose to do nursing, and spoke of their self-images in this regard, as well as how they felt about having made that choice and how they believed others responded to it. In data from the later interviews it was impossible to separate these discrete elements but they appeared in a form revised through the students' experience.

Being a student included aspects of the students' experience that related to the requirements of the transitional status they were occupying on the way to becoming a nurse. Becoming a nurse had to do with what the students perceived about their movement to the inside of nursing, as they embarked upon this status passage. Many of the elements of being a student could be likened to what Broadhead (1983:10,101) has referred to as the "nonnegotiable aspects" of a medical student's training.

To the students, being a student meant, among other things, not being able to make decisions for oneself about many aspects of daily life. "You don't have much choice in this three years," as Ian said in his fourth module (3). For some students, such as Lorna, this was a matter of annoyance at the way they were treated.

- L - Some of them [tutors] treat you like little kids, really, like you're in primary school, and you just have to sit back and just laugh at it to yourself, you just think, "Oh, I don't believe it!" (3)

For others, it represented real inconvenience. This was particularly true for students with family commitments. Frances, who had a young child, had difficulty when shifts were changed and she was expected to adapt, as this entailed complications in her child minding arrangements. It was also true for students trying to maintain social relationships, as Donna described.

D - Your life just goes up the spout, your whole social life goes totally chaotic, you never can plan things, you never knew when you'd be off and on and that. I was engaged, I've split up now, cause it was just gettin' too hard for him, he just couldna cope with, like when I was wantin' to go out, he wouldna be, he'd be workin' the next day and that, and I'd go out wi' my friends from nursin' ... (2)

This feature of nursing education was described by the Oxford Nurse Training Committee in a 1966 report.

The process of interaction between the hospital, as an employing institution, and the student nurse, as an entrant to the nursing profession, is not one that is characterised by adaptation on both sides. The individual student nurse cannot, in any real sense, challenge the institution. She has to come to terms with the demands made upon her or withdraw. (1966:52)

The hospital is no longer the employing institution, but this aspect of what might be referred to as the initiation process into nursing was still present in the experience-mediated images of the students in the present study. Holloway and Penson have also described this dimension of nursing education.

The time structure of student nurses' work separates them from their peers in other forms of education or work. This separation reinforces control. While their peers in higher education have the freedom to decide when to study and when to stop and follow leisure pursuits, nurses are expected to work unsocial hours and days without complaints and without adequate remuneration. Those nurses who accept this and do not drop out of the system internalise this service ethic without much rebellion. (1987:239)

Students in the present study indicated that they had no choice over where their clinical experience would take place, short of requesting a change in placement if they could demonstrate that there were legitimate problems. Some students referred to the "luck of the draw." Valerie said she was "really lucky" in the wards she was allocated to for her general experience, whereas other students in her stream had been allocated to wards where they felt they had not been well treated. Once in a clinical area, the student's control over her experience continued to be circumscribed by the organizational culture of the ward. In a ward with good staff a student might be able to use her initiative and ask for certain experience, teaching, days off, etc, and have the request

entertained. In a ward with a less conducive organizational culture she might be allocated all the dirty jobs, have her requests for tutorials refused or ignored, and so on.

Underlying the students' perceptions of their own powerlessness was an awareness of being at the mercy of staff for the success of their clinical assessment, and hence ultimately their progress in training. Malcolm and Ian both implied this.

M - ... but I just said I'm gonna do what I feel is right, and that's the way I feel best about it, and if they don't accept it, well I'll get a bad assessment. (3)

I - ... it wasn't a bad assessment, it was just mediocre. There were certain areas I thought I did well in that they never noticed. (...) After the interview I wanted to say a few things, but I just left, I didn't say anything, I just felt — it was just pointless. (3)

These aspects of the students' accounts supported an element of the image that a few had suggested in initial interviews, namely that in nursing one was not expected to use initiative but to do as one was told. Some who had not initially expressed such a view implied it in their accounts of their inside images. Thus some students had this element of their initial images reinforced, and for others it became a new element in their experience-mediated images.

Not surprisingly, many of the students' perceptions about being a student had to do with the teaching they received and the learning they were required to do. One feature that loomed large was the pressure of exams; as Julie put it, "my life revolves round the next exam" (3). The magnitude of the students' worry was particularly noticeable during third-round interviews as they anticipated their "half-ways" (NBS assessment of Stage One, since devolved to colleges). Some students were concerned to the extent of having made alternate career plans to fall back on if they should fail their half-way exams and have to leave nursing.

A number of students indicated that the learning they undertook to prepare for exams was rote memorizing. As Eileen described it, the way to pass the exams was to rote learn the Anatomy and Physiology immediately before the exam, because it "only stayed in her head" for about two weeks. In part, this was necessary because the material one had to produce for exams did not relate directly to what students were doing in their nursing practice. In addition, many of them felt that on questions that did relate to nursing, they were expected to include in their answers petty details they would normally just take for granted. Rachel described this.

R - My anatomy and physiology's always a good enough mark, it's my nursing that's not so good, because it's such ... hhh, silly little requests like rememberin' to put in "Please open the window if someone's breathless" or somethin', I mean, things you do automatically.

Students indicated that in order to deal with this, they had to memorize or use mnemonic devices so as not to leave anything out.

Thus it seemed that to the students, exams did not relate realistically to their nursing work, and the teaching they received in college often seemed similarly unrelated. This brought up the well-worked issue of the gap between nursing as taught and nursing as practised. It is not the intention here to discuss at length this phenomenon which has been aired so often in the nursing literature, at professional conferences, and in staff rooms up and down the country. Alexander offers a thorough exploration of the lack of integration perceived by students in their training. This was found to occur when:

(1) practice was not depicted realistically in the teaching, (2) theory was not followed by relevant ward practice, (3) ward staff appeared unaware of the students' stage of training and experience, and (4) there was evidence of conflicting values between college and ward. (1983:207)

There seemed to be two distinct aspects of the gap as it appeared in the present study in students' inside images. One aspect was the difference gap between the way students were taught to carry out procedures and techniques, and the way they saw them done (and were expected to do them) in the clinical areas. For some students, such as Pat, this was a problem.

P - In class they teach you the way things should be done, if it was an ideal world, which as everybody knows it is not. (...) What they teach me in college goes down on a bit of paper, in one ear and out the other. (...)

AK - Is there any value, do you think, in learning the ideal (...) if you can't reach it most of the time?

P - Given as something to strive for, yes, but the knowledge that it's extremely unlikely that we'll be able to achieve that ideal is very frustrating and disheartening. (3)

Pat seemed to have mixed feelings, acknowledging that there is some value in having learned an ideal, but finding the effects frustrating.

For some other students, the difference gap was not a problem. The views of these students were perhaps the more surprising, as it has generally been assumed that the gap is a bad thing. Some students in this study indicated that the gap was acceptable and understandable, even desirable. They imagined that the function of the college was to teach them the ideal way to do things, so they had that as a baseline from which to make modifications, while it was the function of the wards to do things in a practical way. They suggested that if they were never taught the right way they would not know what to strive for, even though in the wards they might be seeing and carrying out

unavoidable (and perhaps quite legitimate) shortcuts or differences in method. Kathy was among these students.

K - College is the perfect example, it's the sort of model, but the model is a perfect example, and you never get that in reality.

AK - So does that not bother you?

K - No, cause I mean, I know that they've got the idealized situation in college (...) everything's perfect, but you're bound to come out and realize that that's not really real life, college isn't, it's telling you what you might expect, it can sort of prepare you to a certain extent. (3)

Some students who agreed that the difference gap was acceptable seemed to have a pragmatic reason for their view, namely that they would otherwise not know how to answer exam questions. Sarah expressed this:

S - I think it does mix, it's just that obviously things are done different in the ward because there may be times when they do short cuts, which you're told not to do at college, (...) but I always remember the proper way you're supposed to do it so that if I'm doin' an exam, I do it the proper way, and I forget totally how you do it in the ward. I mean, I think (the gap) is acceptable.

AK - Is it useful to have learned it that way in the first place, what you're calling the proper way?

S - Yes, it is, because then you know it all, and then you could just sort of cut it down when you do come onto the ward, but you still know everything that you should know.

AK - So you wouldn't want to learn it the short cut way?

S - No, cause, well (...) if there was just the one way, and it was like the short cut way, then that would be fine, but I mean I wouldn't like to do it the short cut way on the ward first, then have to learn the long way, cause you'd think, they never did it like that in the ward, you know, where it's easier learnin' it at college where you're never actually doin' it practically, but doin' the short one the practical way. (3)

"Everything that you should know," in Sarah's view, seemed to relate only to exams, and she did not seem to see any absurdity in the notion that the ideal was well worth learning even though that was its only purpose (as she perceived it).

These elements of students' inside images have also been identified by Melia:

The students have to sort out some way of dealing with the situation in which they find themselves, and they appear to do this by accepting that there are two versions of nursing, each with its own rationality. These versions of nursing do not sit happily together; one is appropriate to the college setting, the other to the clinical areas. The students are, then, able to recognise when one version is appropriate and the other not, and act accordingly. In other words, they can produce either version for the appropriate audience as and when the occasion arises. (1984:140-1)

The second aspect of the gap had to do with omission rather than difference. Students cited instances in which college simply did not prepare them for what they faced in the wards. This was a particular problem with students who went to psychogeriatric wards for their geriatric experience. Carol expressed this.

- C - ... geriatrics was a classic example. We had a 2-hour lecture on psychogeriatrics but we'd 13 weeks in a ward, but I mean, 2 hours doesn't cover 13 weeks o' work, you just didn't know what you were goin' to, while at least people that were goin' to geriatrics had a vague idea about what was happenin' but we didn't. (3)

Students in this position felt doubly short-changed: they had not been prepared for the experience they actually had, and they did not get the experience they had been prepared for. This particular issue is well explored by Cruickshank (1991) in relation to geriatric and psychogeriatric experience.

Another variation of the omission gap occurred when students in the final week of a module received teaching which would have been useful to them during the clinical weeks of the module. Rachel described this delayed teaching:

- R - You did the sorta basics the first week, and then when you came back, the last week, you did all the things that you'd seen in the ward but you had no experience from college, no theoretical experience. (3)

A specific example that several students mentioned from their psychiatric module was having to cope with patients having epileptic seizures, only to receive teaching on the subject in college during the final week of the module. Another example, offered by Yvonne, related to the medical module:

- Y - The last week, we had blood transfusions, and you'd see that every day. Something like that, and it was intravenous infusions in that week. (3)

The students were virtually unanimous in believing that the arrangement of modules (a week in college followed by thirteen weeks in the clinical area followed by a final week in college) was unsatisfactory, with too little college time at the beginning and too much at the end. A number thought college time should be interspersed with clinical experience so they would not lose touch with the college side of things, and so they could receive all the relevant teaching while they still had time to put it into practice. By their third interviews, however, they seemed to have accepted the received excuses as to why it was impossible, despite several years of students (and teachers) making the same criticism, to come up with a more rational arrangement.

Thus students' inside images seemed to contain elements of resigned acceptance of inadequate educational procedures and a notion of having to go into clinical situations blind.

There was an interesting side issue related to the gap that fitted with the concept of moving inside that had begun to be identified from initial interviews. This was the observation made by some students that knowing about things was not the same as experiencing them, however accurate and realistic the knowing-about might be. Carol suggested in her third interview that no matter how much was taught in the college, "th'only way you learn" is by seeing and doing things in the wards. Mary Ann implied the same view.

MA - I dinna think, until you're on the ward and see actually whatever ... (...) they can tell you about fit's gonna happen, but really ... (3)

Natalie described in her second interview the way in which things she had never imagined had become known to her. "I think it's you don't realize what goes on, unless you've been in a hospital," she said. Angela similarly said,

A - What you first imagine, it's bound to change, because there's so many different things that have to be done that you don't even know exist before you start. (...) You come across something new all the time. (2)

These accounts seem to support the notion of the three positions identified earlier from which nursing was viewed: the outside position, as of a spectator; that of the informed outsider (the beginner), who has been taught about things but has not yet experienced them; and that of the insider who not only *knows about* but *knows* with the understanding of experience. Psathas has offered a description of this phenomenon.

Experience in the role rather than didactic teaching about the role, produces changed perceptions and, in a sense, a restructuring of the phenomenal world of the actor. The freshman or neophyte has only the definition of the role as presented in didactic teaching or popular attitudes as the basis for his perception; however, with experience, things are not the same as they were because the actor is no longer the same. He cannot perceive things in the same way because he has changed. (1966:63)

In first interviews students were neophytes in the process of becoming informed outsiders, though some were trying to imagine themselves as insiders, whereas in later interviews they were speaking from an increasingly inside vantage point. It should be pointed out, though, that there was an outside-inside dimension to various types of nursing, not just to nursing as a whole.

One implication of this is that a gap seems bound to exist even when students have accurate knowledge of what to expect in the real world of the clinical area, because they will still have to adapt to being a participating insider, which can never be fully understood from an outside vantage point however well informed a person may be. This might be likened to the difference between having accurate information about

bereavement, and actually experiencing bereavement. The first (an outsider's image) may be correct in a cognitive sense, but it cannot equate with the understanding that comes about through experience (an experience-mediated image).

The issue of contact with college was one which came up repeatedly in interviews. Students expressed real appreciation of the attention of clinical teachers (CTs) and seemed to find it helpful support for bridging the gap, but such attention was patchy and inconsistent. Some students had had a great deal of attention from CTs and were very complimentary of their efforts. Others had received less, and a few had not worked with a CT in any of their four modules by the time of their third interviews. In one area, a particular CT had repeatedly made appointments to work with students and repeatedly cancelled. One student was annoyed and seemed suspicious of the CT's excuses. The others accepted the CT's excuses and made comments alluding the fact that it was beyond the CT's control, as Wendy did.

W - The clinical teacher cancelled every single session with me [laughs]. He popped in to apologize, and he'd made another appointment to see me and he hadn't turned up anyway, so he came to apologize about that, and the next time I saw him, [the consultant] came to do a round when he was speaking to me and gave him a bawling out for making too much noise, so we'd to go into the sluice for a chit-chat, but I never got any [teaching], but it was just one thing and another, it was just circumstances there. (3)

These students, and others on many other occasions in a variety of wards, seemed to excuse their CTs' lack of attention to them on the grounds of supposed unavoidable responsibilities in the college, but most of them indicated that they did miss the teaching. The general impression from the interviews was that the amount of teaching the students received was primarily a function of the effectiveness of the clinical staff, not the college staff.

Another topic that came up repeatedly in relation to college was the issue of written work. Again this feature of student experience was uneven, some students having had no written assignments other than exams and others having had written work in every module. Not all considered it a treat to get off lightly in this regard; some preferred to have written work, though there were frequent comments about the difficulty of having to do academic work after a hard day in the clinical area. Ian said about written work:

I - I haven't had any. I haven't had any since I started. Surgical I had a couple of exam questions. (...) I wish I had, that would have been easier when it comes to revision. When it comes to doing nursing care questions, I know most of the answers, but puttin' them on paper, I seem to have a problem. (3)

(Practice exam questions did not seem to count as "written work".) Helen expressed a similar view.

H - Our class has not tended to get a lot of work for college. The class behind us have got different senior tutors, and they seem to get a big project every module, which we haven't.

AK - Would you have wanted something?

H - Yeah, because it would make me work more [laughs]. I left everything till the last week every time. (3)

Though the students did not use the term, what they seemed to be describing was evidence of a strongly examination-led curriculum. Both Ian's and Helen's reasons for wanting written work were exam-related.

Students tended to describe themselves as feeling more like workers than students. It was commonly expressed throughout the interviews that they believed it was unreasonable to be expected to work a full week and do studying as well.

V - It's been really difficult, because the last thing you want to do when you come home at night is to sit and study. I mean, your days off you're too busy just sorta catchin' up on sleep and washin' and ironin'. (Valerie 3)

S - I feel like a worker (...) you don't have time to be a student. I mean, if I'm workin' on a 9-day shift, I don't have time to sit up at night and study, cause all I want to do is go to bed. (...) They should cut your hours of work a wee bittie if they expect you to study at the same time, but on the other hand hundreds of people have done it before me, and hundreds are gonna do it behind me, so I don't see why I can't do it, you know? (Sarah 3)

Sarah hints at an element of becoming a nurse, that is, acquiring the mantle of belonging through survival of initiation processes.

Another element of what students seemed to imagine as an inevitable initiation into nursing was overcoming certain dreads. These came to light during first-round interviews, and in later interviews students told of encountering their dreads. These included: dealing with dying patients and their families, dead bodies and cardiac arrests; for female students, giving intimate care to male patients; assisting at procedures such as lumbar punctures; seeing ECT; and giving injections for the first time. Many of these had ceased to be a worry, in particular giving injections and bathing male patients. Students tended to remember their first experience of the dreaded task, but most were able to laugh about it by now.

P - (At my first injection) my hand shook so much drawing the thing up, and I made a complete muck-up of giving it, you know, sorta the first thing, because the plastic bums you get to practice on at college [laughs] (...) you hardly need any pressure to get the needle in. (...) Now it doesn't bother me. (Pat 3)

B - All my friends that I'd gotten to know were goin' to female wards, and I thought, oh no!, am I th'only one goin' to male? I did say, "Oh no!", ken, but they just sat and laughed and said, "Och, well, you'll soon get used to it." (...) I never really had much to do wi' men, really, and that, I mean, it was quite hard, my first couple o' days, but I mean, you soon forget. (Becky 2)

There were clear connotations of stress in the features discussed above: facing exams, coping with the dual student-worker identity, encountering dreads, and so on. There were also many other sources of stress involved in being a student. Perhaps the strongest of these was dealing with death, which was discussed separately earlier. A related feature of being a student was the students' need for support in the face of the stresses they perceived. The sub-theme "stress and support" is specifically explored later in this section.

Being a Student 2: Settling In

The experience of settling in came up in many of the later interviews. Settling in was the process of moving from a feeling of newness and strangeness in a clinical setting to a feeling of familiarity and comfort with the surroundings and routines. It was the process the student had to go through in adapting to the inside position of a clinical experience. Its antecedent in students' initial images of nursing seemed to be the presence in their pictures of new students who did not know as much about what to do as the more senior staff did. One of the major differences in their experience-mediated images was that each student described settling in from a purely subjective perspective. That is, it was something that happened to them personally, something they had to do, rather than being something they pictured from the outside.

Findlay found that a student's experience of settling in was a product of the interaction between "the baggage of personal characteristics" with which she arrived at a new placement and the organizational culture of that clinical area (1991:62). Interpersonal relations with permanent staff constituted one of the primary elements of the organizational culture. These findings agree with the accounts of students in this study, and reinforce the notion of a relationship between settling in and the good and bad staff sub-theme.

One particularly interesting property of settling in was its recurrent nature. It was not only a feature of students' first placements but had to be re-experienced in every clinical placement. To some students, this came as an unwelcome surprise.

A - It took me longer to settle there (2nd ward) than it did in my first ward, but in my first ward I was brand new, and ... it was fine, but this ward, because you'd been somewhere else and the setup and everything was different, your ward routine was a bit different, you did things at different times ... (Angela 2)

MA - I'd been there thirteen weeks, and I knew what I was doin', knew where everything was, I knew the patients, [but then] goin' back to bein' lost, nae kennin' where anythin' was. (...) I seemed to be standin' and everyb'dy zippin' back and for'. (...) I think it's maybe like the feelin' o' bein' stupid again, after you've gotten to a certain point in your last ward. (Mary Ann 2)

Y - It's awful to start wi', you know. (...) You've to take a while, it's like they have a routine in every ward, you just have to find out every time [laughs]. I find that every time I start somewhere, it's like starting all over again. (Yvonne 3)

Curiously, some of the students who were aware that this re-settling had been inevitable in each clinical experience they had encountered so far seemed to believe that a time would come during their training when it wouldn't be necessary. Wendy said, "This is it, you're always new until you're into your second level," implying that she did not expect to feel new any longer once she had finished her first stage of training.

Findlay's findings suggest that Wendy was likely to be disappointed in this expectation: "Students still had high levels of anxiety on moving wards, even towards the end of their training" (1991:75). An explanation for this may be that even when students move to clinical areas that are similar in type of nursing to others they have experienced, the organizational climate is still new.

The role of permanent staff featured strongly in students' accounts of settling in. As Gail described it, "They determine whether it takes you a week or, you know, a month." Some staff seemed to expect students to jump in at the deep end and learn to swim for themselves, showing little awareness of the fears and uncertainties the students were feeling; some displayed negative attitudes towards the students; some seemed to treat all students the same, as if they were interchangeable components to fill an empty slot on the duty roster. Melia found many of the same features in her study.

The students' accounts suggest that the qualified staff expected the students to become efficient workers in a short space of time; also, that the staff judged the students by their ability to function efficiently as workers. The trained staff, it seems, expect the students to pick up the 'job' and fill in the vacant slot on the ward. The students gained the impression that trained staff did not make distinctions between individual students and dealt in stereotypes of first, second and third level workers according to a generalised notion of progress through training. (1984:143)

These components of students' accounts in the present study fitted within the sub-theme bad staff as discussed earlier. On the other hand, however, many good staff members facilitated students' settling in effectively, and this was often what encouraged students' positive images of certain wards or types of nursing.

Staff alone did not account for all aspects of the ease or difficulty of settling in. Other factors included the type of nursing, what the student expected in that type of nursing area and what sort of preparation the student had received in the college. The array of perceptions is illustrated by the following students' accounts.

P - I was absolutely terrified about coming down here [A & E]. I didn't know what to expect. (Pat 3)

- F - ... the psychogeriatric ward, I wasn't prepared for the actual dementia. (Frances 3)
- D - This [mental handicap] was a total shock to my system, this. (...) It really takes a lot of getting used to. (...) I like it now. I hated it the first week ... the second week I was still a bit dubious. (Donna 2)
- G - I didn't know what to expect at all. (...) It took a while to get, like sorta come outa my shell, to sorta be able to talk to people and be able to ask questions. (...) It was just completely different. (Gail 3, about geriatrics)
- W - I knew if you had somebody really disturbed, there was a chance [of violence], because of their state, and you could get hit, but at the same time, you know, they [college tutors] really went on about it so much, by the end of the week, I honestly remember comin' out of college thinkin', I wish I'd never gone to college for this week, and just gone straight into the ward, because I was really apprehensive after college, after what they said. (Wendy 3, about psychiatry)

Although there were differences as to which areas engendered anxiety in which students, it seemed that certain types of areas were more likely to be problematic for students' settling in. These included psychogeriatrics, psychiatry, mental handicap, and high-technology medical or surgical areas.

Often, however, students were surprised at how well they adapted to areas they had worried about, and when this happened it was usually attributable to facilitation by good staff. Carol described being "terrified" on her first day in a psychiatric ward, but soon felt comfortable and enjoyed the experience, because staff were "really really helpful" (3). The reverse also occurred on some occasions, when a clinical area that a student had not worried about turned out to be difficult to settle into because of bad staff. Ian found it hard to settle in a surgical ward where "you seem to be so often by yourself or with another student, and you're never quite sure what to do" (2). He never became really comfortable in this setting, because the staff did not offer adequate guidance for his needs and never gave him the feeling that they knew enough about him to assess his work accurately. The link between settling in and staff was therefore a strong one.

The settling in sub-theme provided evidence of the students' moving from informed-outsider to insider positions, demonstrating the potential contrast between the images perceived from the two vantage points. A student might, for example, picture the behaviour of psychiatric patients as frightening, and in her psychiatric module the pictured behaviour might indeed be present, but the student's inside image of psychiatric nursing might have lost the element of being frightening. This might come about simply through familiarity, but there was a strong indication that support from staff played a major role in facilitating the development of a comfortable image. The same type of process could occur in reverse, as when a student who had had an initial image of enjoyable work found that her inside image of that type of nursing had lost the element of enjoyment. This could happen even if the work did not turn out to be very

different from that which she had pictured. It might be based on the difference between picturing and doing, or again it might be related to the quality of support offered by staff to facilitate the student's settling in.

Being a Student 3: Stress and Support

Students in this study were virtually unanimous in finding a lack of support mechanisms built into the system to assist them in dealing with the stress they encountered. Some of them were quick to articulate their views as to this lack.

E - You find that nobody cares about [student] nurses. (...) We don't have, I don't know, we should have a lot more discussion sessions and yoga classes or whatever, you know, we should have lot more care taken, it's a caring profession, but they don't care about their nurses ... the NHS. (Eileen 2)

C - ... there's not a lot for us. If we have any troubles, you're supposed to go to your senior tutor or whatever, but I mean, that person doesn't know you fae Adam, so why go and tell a complete stranger something that's bothering you? (Carol 3)

Ian in particular found the institution's lack of attention hard to understand.

I - All the other jobs I've done, the sort of hierarchy have always made an effort to keep the morale up of people, and there was perks of one sort or another, but mostly in nursing there isn't any, and they'll get away with as much as they can, take as much from you as they can. (...) They're not making any effort to make it more enjoyable. (...) Everywhere I've worked [in nurse training] morale's been a bit of a problem. (Ian 3)

It seemed that the system's lack of support mechanisms to help students deal with stress, and the absence of extracurricular facilities along with the distortion of their social lives, constituted a package of factors that the students perceived as destructive to their well-being. This situation was doubly hard for them to accept given their entry image of nursing as a caring profession. Their inside image seemed to have taken on an element of uncaring-ness in nursing towards its own members, a sort of tarnish to the belonging.

A number of studies over the years have addressed this issue. Menzies noted that in the hospital she investigated there was little support offered for students' necessary development.

...the training system (...) pays minimal attention to teaching events oriented to personal maturation within the professional setting. There is (...) no small group teaching event concerned specifically to help student nurses work over the impact of their first essays in nursing practice and handle more effectively their relations with patients and their own emotional reactions. (...) The training system, oriented as it is to information-giving, also deprives the student nurse of support and help. She feels driven to acquire knowledge and pass examinations, to

become 'a good nurse', while at the same time she feels few people show real concern for her personal development... (1960:21,32-3)

The Oxford Area Nurse Training Committee commented:

The fact that student nurses have been active members of social clubs and school societies may be taken into account in their selection, yet once accepted, opportunities to continue such activities are denied. (1966:53)

The Committee also reported:

Because students work different hours from other employees, both inside and outside the hospital, the hospital provides both accommodation and entertainment to compensate them for their inability to find these two things easily outside the hospital. The provision of such facilities reinforces the isolation of the student nurse from the wider community and encourages her to look inward to the hospital for the satisfaction of her needs. (1966:52)

It could be argued that the failure of the institution to make such provision, as appears to be the norm from the current students' accounts, is more damaging than the isolation-engendering provision, as it leaves them with nothing.

Mackay found evidence of the system's failure to provide resources to make up for the distortion of students' social lives. She quotes a student who said, similarly to Eileen, "They call nursing the caring profession but, you know, who does care for the carers?" and points out that "nurses' need for an 'independent ear' at work is not met" (1989:113).

Most students in the present study readily acknowledged that some clinical staff had, on an individual basis, recognized and met their need for support in relation to specific events that occurred in the clinical area, as has been discussed earlier. In addition, some indicated that they had received thoughtful support from members of the teaching staff at the college. However, they indicated that this was attributable solely to the efforts of individuals, and not to any institutional recognition of their needs.

A number of students indicated that they had expected student counselling services to be available to them. There was an Occupational Health service which college staff seemed to see as a resource for counselling, but the students did not perceive it as such. They gave two reasons for this. Firstly, when students had repeated absences due to illness, they were sent to OH, and they tended to perceive this as a suspicion that they were "skiving". Hence OH acquired a disciplinary connotation. Secondly, they knew that OH communicated with the college staff about certain things (such as their admission medical), and they therefore did not feel secure as to confidentiality.

Many students had found their own ways to find support in times of stress. Some took the fairly obvious step of approaching staff, and this was often successful, as on

many occasions staff were concerned and willing to take the time to offer support. It was also common for students to find support amongst fellow students or from family. This might take the simple form of “having a jolly good moan when you’re havin’ your break”, as Frances (3) put it, laughing. She also made the point that “an awful lot of them seem to go out and drink quite a lot.” “Letting off steam” seemed to be one of the ways students dealt with the results of stress, if not the causes.

R - I usually speak to my roommate and sort of say it to her. I sometimes cry. (...) I get quite frustrated, really sort of throw things about, you know. (...) I wouldn’t say I bottled it up, cause I usually go home and tell my Mum or my roommate. (Rachel 3)

D - You act so sorta grown up when you’re here, and you’ve got to go out and act the total opposite, I think. You’ve got to let loose sometimes. (...) You do need a release, you’ve got to have a release, I think. (Donna 3)

Windsor mentioned the mutual support students provided for each other as found in her study of final year students.

The most frequent response about other students was that they provided essential emotional support. The students perceived that only nursing students “really understand what they go through in school” and, therefore, they talk with nursing students about school-related problems and issues. (1978:153)

In the present study, as was mentioned earlier, it became evident that the researcher herself was serving a supportive function for the interviewees merely by listening to them.

Stress and the need for support were thus evident in the students’ accounts of their inside images. In their initial images, they had described elements of stress, so this aspect had been reinforced. It was interesting, however, that in later interviews, a number of students described having expected more system support to be provided for students and nurses, though this had not been expressed as part of their initial images. Several possibilities exist here. It may be that, as with other aspects of their initial images, there was an error in what the students remembered picturing. Another possibility is that they may have had a notion of support being available for nurses but had not expressed it. This might have happened simply because it did not come up in the conversation, but it would seem that if that element was present, it cannot have had a high profile or it *would* have come up. If present, the fact that it did not loom large in the picture might be attributable again to the difference between their perceptions from outside and inside vantage points. That is, looking in on nursing as a spectator, the understanding of how the stress felt did not yet exist, whereas from the inside the stress was actually experienced, and the need for support therefore took a prominent place in the inside image.

Becoming a Nurse

The students in this study found that becoming a nurse wrought changes in themselves as well as in their life styles. This sub-theme had appeared in the data from their initial interviews, and many of the students had anticipated certain elements of becoming a nurse as they experienced it.

The transition that had been foreshadowed in initial interviews was apparent in later interviews, that is, the staged move to inside nursing. For most of the students, this entailed a growing identification of themselves as nurses. Gail exemplified this when she said in her second interview, "I like just sayin' that I'm a nurse, because I like bein' a nurse, it's like doin' somethin' that you really want to do and bein' able to tell people."

Some students, however, were not so sure about moving into nursing. Zena was the most definite case, in that by her second interview she had decided to leave training. "It's maybe just not quite what I'm for," she said. She did indeed resign approximately a month after that interview.

A few students had had moments of thinking they would give it up. In Valerie's case, it was not because she doubted her desire to nurse, but because she had felt at one point that she had been better treated, felt more "included in", as an auxiliary than she was as a student, and she thought of returning to being an auxiliary. It seemed that in her inside image, the belonging seen in her initial image of nursing had not been borne out.

Some students were less definite in their doubts. Julie, for example, spoke in her third interview about what she would do if she weren't doing nursing, a subject she had been giving serious thought to, in case "I fail an exam or I just decide that I don't want to do it any more and I can't take any more." Oddly enough, Julie stated in the same interview that she was "proud to say 'I'm a nurse'," implying a degree of ambivalence in her identification with nursing.

A number of students saw themselves finishing their training and then moving on to something else.

R - I'm not honestly sure, I mean, I don't know if I'll stick it at the end of three years. (...) I wouldn't say I was happy, I wouldn't, em, I never seem to be happy, I mean, in [medical ward], I felt as if I fitted in perfectly, and [surgical ward] I've enjoyed my ward, the folk are great, but I don't feel as if I fit in (...) and I just don't know what it is that makes me think, well, I don't know if I'll ... I'm still not very sure if I've done the right thing. (Rachel 3)

T - No way I could stay in nursing. (...) I've seen it now, I'm just not cut out to be a nurse. Well, I think I'll enjoy it for the three years that I do it, cause I quite enjoy it just now, it's not a bane or anything coming into work every day. (...) After the three years, I'll either give it up then or go abroad for a while and work, and then leave after that. (...) It just doesn't stimulate me enough,

mentally, it just doesn't tax me or anything. [If I had it to do over again] I would go to university, or college, whatever sort of education. (Tina 3)

- C - I still fancy it [police work]. I really really enjoy nursin', but I mean, who knows what's goin' to happen in the future. Just now, I'd like to staff nurse for a wee while and then see what happens. (Carol 3)

For other students there seemed to be a lurking doubt about staying in nursing, though they didn't express it directly. Ian used the phrase "if I was gonna do nursing for a long time" (3). So although he said in the same interview that he was glad he'd decided to come into nursing, there was an "if" about sticking with it.

The reason for quoting students at length on this matter is that the occurrence of doubt about the choice of nursing seemed to be a particularly meaningful feature of the movement of the sub-theme "becoming a nurse". In students' initial images, doubt did not come into the picture, but it appeared as they moved inside and experienced nursing first-hand. A careful inspection of the interview data suggested that their doubts were partly the result of feelings of a mismatch between themselves and "real" nursing, and partly attributable to a disillusionment arising from the disparity between their ideal image and the elements of their experience which they perceived to have fallen short of the ideal. Some of these elements have been discussed in the preceding sections, and the processes involved as students dealt with the disparity are discussed later.

Another feature of becoming a nurse was that as novice nurses, students were aware of acquiring certain abilities and they felt themselves gaining in confidence. Rachel believed that one thing that had given her more confidence was having newer students start in a ward once she herself had settled in. Some students felt better able to establish interpersonal relationships, as Yvonne and Wendy both described.

- Y - I've never been a loud person, I've aye been shy. (...) I think I've, I've nae really gotten loud, but I think I've come oot o' mysel' a wee bittie mair. (3)

- W - I can approach people ... I'm still not outgoing, but I can approach them a lot better. (2)

Becky similarly said, "I would say maybe I'm comin' out of myself," and "I find it easier to talk to people more than I did" (2). In her case, there was evidence of this change during her interview. She had appeared terribly shy at her first interview, but by her second she appeared noticeably more forthcoming and articulate.

Some students had become more confident of their own judgment. Carol said, "I can argue wi' somebody now and win" (3). Donna trusted her judgment of her own abilities.

- D - I'd be the first person to turn round and say to somebody, "I don't want to do this because I don't feel like I'm capable enough to do it" (...) but if I feel that in myself I can do something, then I'll go and do it, and I'll be able to do it fine. (3)

There were many ways students felt they had changed as people. In particular, the younger ones tended to feel they had grown up faster than their contemporaries who had gone to college or university or who had taken jobs directly after school. Helen indicated that she felt this, though she attributed it as much to “the age I’m at” as to the influence of nursing. Other students thought this change had come about primarily because they had seen and done things which involved aspects of life that those contemporaries would not yet have encountered. This, along with the social implications of their duty schedules, had led many of the students to develop their social lives around friends they had found in nursing, falling away from their non-nursing friendships.

Many students believed they had become more understanding, more patient and tolerant. Eileen thought this about herself, as did Angela, though Angela indicated that her understanding had its limits.

AK - Do you feel that you’re different in any way now from say the person you were when I first talked to you, do you think you’ve changed?

A -[sigh]...[laugh]... That’s difficult to say. I might be a bit more understandin’, I think. [laughs] Em ... or maybe not, you know. In some ways I think I am, and in other ways, you know, like at home if anybody complains about something, you know ... (3)

She didn’t complete this thought, but the implication was that she felt herself to be less understanding of family than of patients.

A number of students believed they had become more serious (or “boring”, as Yvonne put it) as a result of their experience in nursing.

C - ... my best friend (...) says to me, “Before you started nursin’,” she says, “I could never have a serious conversation with ye,” and she says, “but now [laughs] we can sit down and have a few serious ones.” I am a lot more serious than what I was, although I’m not completely serious [laughs], I don’t think I’ll ever be completely serious, but ... it opens your eyes to a lot o’ things. (Carol 3)

Y - I do [think I’ve changed]. I think I’ve gotten boring. [laughs] Me and m’other friend was speakin’ about it not long ago, I say t’er, “Do you think you’ve changed?”, she says, “Oh, I really have.” Like when you go home, some people that you went to school with are still ... em, sometimes if they go out to have a laugh, you think, “Tsk!”, you know? [laughs] “Behave!” or “Stop that!” (Yvonne 3)

It was interesting that several students mentioned having spoken about this with friends recently, which indicated that they were thinking about the changes in themselves before I asked them to reflect on them.

Mary Ann seemed to be particularly aware of the changes she was going through.

MA - You're very idealistic and you think you're nae green, but y'are, and fin you look back, you can see a difference ... I feel you grow up more ... I feel probably that I've gained more fae it than if I had bade where I was at [working as a receptionist], I would have been different, I think. (Mary Ann 3)

Sarah's explanation for why "you can't be the same person" once you go into nursing was that nursing makes you "learn a lot about yourself" (2). This seemed to be particularly true for Ian, who seemed to have gained considerable insight by the time of his third interview, though he wasn't aware of it until he was asked. Having indicated in the earlier interviews that he hoped nursing might push him to become less shy and more outgoing, he now said he no longer had that goal.

I - I've definitely changed, I've never thought of it. I think if anything, I've become quieter. Before when I was quiet I'd try and make myself go forward, but now it doesn't matter to me, I'm just me. I find I can do as well with anything as anyone who's (more outgoing). I think I can do just as well, I'm just a quiet person, I like to be quiet sometimes [laughs]. I'm happier in myself then, I'm more content how I am. (Ian 3)

Ian did indeed come across at interview as a shy person, and yet he demonstrated considerable ability to express himself in a descriptive and individual way.

Thus for these students becoming a nurse involved not just learning about the world of nursing as they moved into it, but undergoing personal changes and learning about themselves. Some of the changes they perceived in themselves, such as gains in understanding and interpersonal skills, were congruent with qualities they had imagined in the good nurse in their initial pictures. Further, some of their accounts bore out the notion from their initial images that nursing would change a person and would become inextricably part of the person and/or her life.

SUMMARY OF INSIDE IMAGES

As was the case with their early images, the students' inside or experience-mediated images showed considerable diversity. However, a number of common threads were woven through many of their accounts. A diagrammatic representation of the inside images can be seen in Figure 6.1 (pages 224-5.)

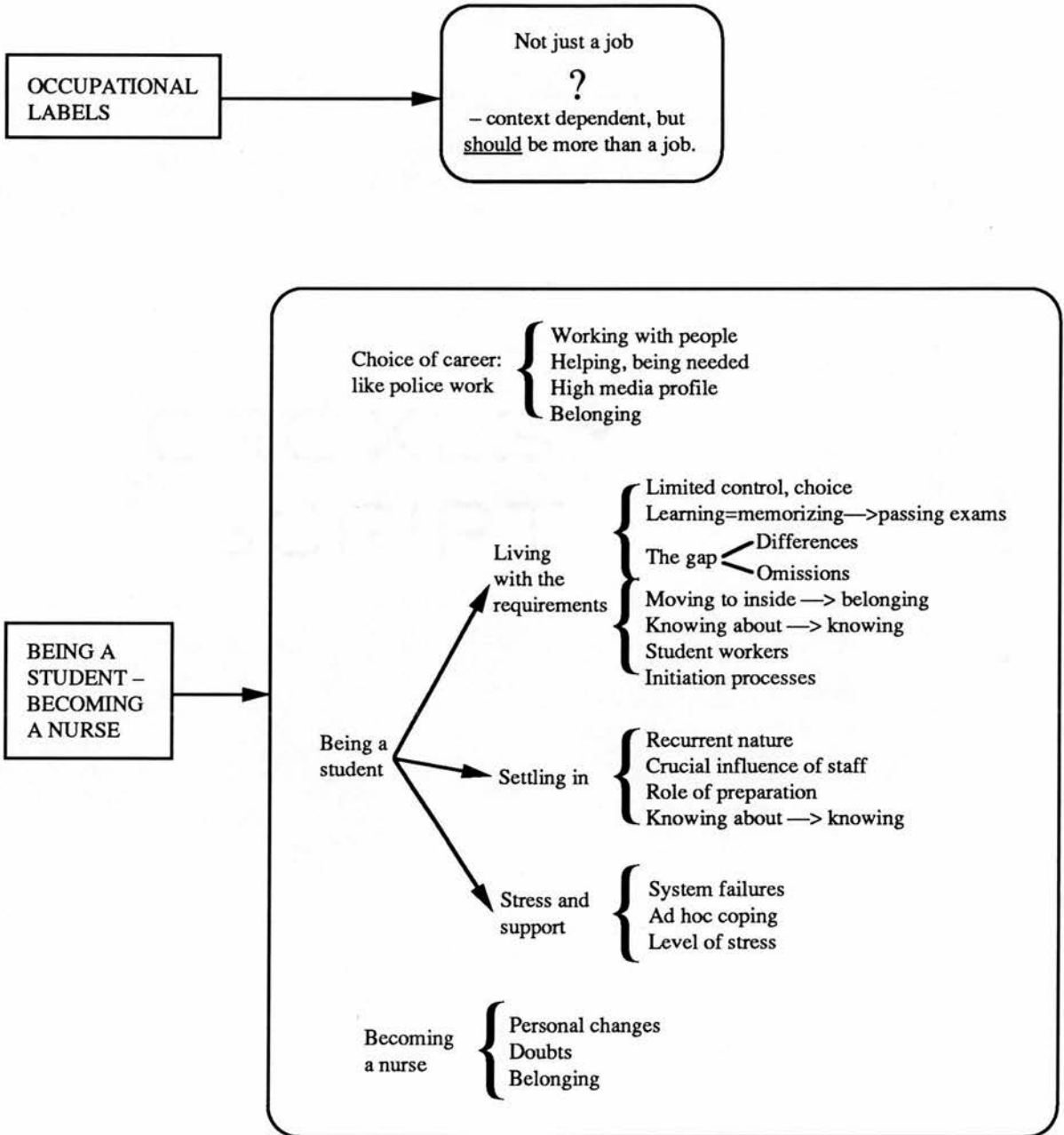
With regard to their pictures of nursing, there was a continuing tendency to view general (adult) nursing as typical or real nursing. The pictures had altered as to the degree of formality, and there were area-specific variations identified.

The good nurse theme had enlarged to encompass staff, both good and bad, and this formed a strong element in the students' inside images. In addition, the object of the nurse or staff's goodness (or badness) had expanded to include students themselves

(See over for page 224.)

Figure 6.1(b)

Inside image categories and their properties



as well as patients and their families. In fact, students mentioned this perspective more often than they mentioned staff attitudes and behaviour towards patients.

Within the students' images of what nursing entails, the typical work of the nurse was still seen as general (medical and surgical) in nature, and communication was still an important part of this. The good and the bad retained a high profile, though some of the properties altered. By and large, the elements students had imagined as the good in nursing were still strongly present in their inside images, and they gained satisfaction from the things they had pictured as rewarding. However, not all elements of the bad remained. Some minor ones had virtually disappeared from the students' later images, though the memories of them were often retained. Some new elements emerged, in particular the presence of bad staff. And some elements originally imagined as bad were found to have good qualities, most notably the rewards that were possible in the care of the dying. The students' ideas about involvement with patients retained their paradoxical nature, and many of the instances students recounted to illustrate this element revolved around death-related experiences.

The occupational labels students would assign to nursing did not undergo much change, apart from an occasional instance of greater willingness to see nursing as a job, especially during experiences in clinical areas the students were not perceiving as positive working climates.

The students' images of the phenomenon of "being a student – becoming a nurse" filled out with experience. The conceptual links perceived between nursing and police work strengthened. The realities of being a student became personally known to them, and the gaps between their images and nursing as they experienced it, as well as between nursing as they were told about it and experienced it, were revealed to them. Again the significance of staff support was evident. Finally, students' inside images were linked with the changes they perceived themselves undergoing as they took on the identity of "nurse".

This analysis of the conceptual organization of the categories and their properties thus revealed, along with a number of differences between the students' accounts of their entry images and their inside images of nursing, certain abiding features which had been present in initial interviews and tended to retain a high profile in the later interviews. These can be identified in the relevant sections of Figure 6.1 (pages 224-5).

- 1) *Nursing as working with and helping people:* This was evident as part of the good in nursing, as a characteristic nursing shared with police work, and as an implicit component of the communication and the involvement that nursing entails.
- 2) *Nursing as more than just a job, requiring motivation and commitment, conferring a sense of belonging, and bringing about changes in the person who becomes a nurse:* Although it was true that whether students were finding their nursing work

to be more than just a job was dependent on the specific context, it seemed clear in their accounts of how they pictured nursing as an occupation (that is, nursing as it is meant to be) that nursing was still seen as more than just a job. Motivation to do nursing, and a commitment to it, appeared in relation to the nurse's need to tolerate elements of the bad components of what nursing entails; this required the aspiring nurse to be right for nursing and have a strong desire to do it. The notion of belonging permeated many aspects of the conceptual scheme. It underpinned some of the differences between good staff and bad staff, and was implied in students' accounts of nursing as a career choice (and of police work as a potential alternative career choice). It featured in their experiences of being students and becoming nurses, including aspects that acted as initiation processes. As a result of all these, becoming a nurse led to personal changes in the individual, and thus that expectation expressed in initial interviews was reinforced by experience.

- 3) *Nursing as being rewarding, through knowing or seeing that you have helped, and through interpersonal relations with patients:* It was clear that these aspects of the good of what nursing entails were retained from entry images virtually intact, and this included the personal rewards of involvement with patients and families.
- 4) *Nursing as entailing a drain on one's personal resources:* This was particularly evident in relation to the personal cost of involvement, especially in relation to death, and in the other sources of stress encountered as part of being a student on the road to becoming a nurse.
- 5) *Typical or real nursing as adult general nursing:* This feature of students' images remained clear from the beginning to the end of the study. It was retained in their pictures of nursing as viewed from the inside, and in their accounts of the tasks that characterized the typical work entailed in nursing.

Chapter 7

SHIFTING IMAGES

This chapter considers the processes through which the student nurses' images of nursing developed as they progressed from entry to the real world of clinical nursing. In the discussion, reference is made to theories of imagery as discussed in Chapter 1.

Exemplary quotations are offered to illustrate the processes. A few of the examples are direct quotes from students whose words provided representative evidence of the process being described. These are not one-off cases with regard to their meaning, but typify statements made by several students. The other quotations are composite examples, representing a type of comment made by a number of students.

A schematic model of the processes of students' image development, derived from the analysis of their accounts, is displayed in Figure 7.1 (page 229). This offers a visual representation of the conceptual scheme underlying the discussion in this chapter.

Overview of the Processes

Broadly speaking, as students experienced the clinical world of nursing, one of two things happened with regard to their initial images of nursing: either their images agreed with reality as they perceived it or they did not. It must be stressed here that the students' images were not whole entities whose parts were inseparable. As part of the "carapace" of images enveloping them (Gordon 1972), they comprised numerous components which, though interrelated, were capable of behaving independently. Thus there might be certain elements of a student's initial image which agreed with her nursing experience while others did not.

Analysis of the data revealed that a number of processes seemed to operate as the students dealt mentally with the agreement or disparity between their images and reality as they experienced it. In the discussion which follows, the processes are discussed as discrete entities, which they were not. There was much overlapping between processes. Occasionally a comment to this effect is made, but there are many more cases of overlap than could be discussed in detail.

The terms chosen to identify the various processes have been assigned by the researcher, though they relate to ideas on image processing as discussed in Chapter 1. It is the meaning implied in the students' accounts, rather than the precise words they used, that has provided the material for the discussion.

One curious feature of the students' accounts is worth mentioning at this point with regard to their perception of agreement between their image and reality. Many students,

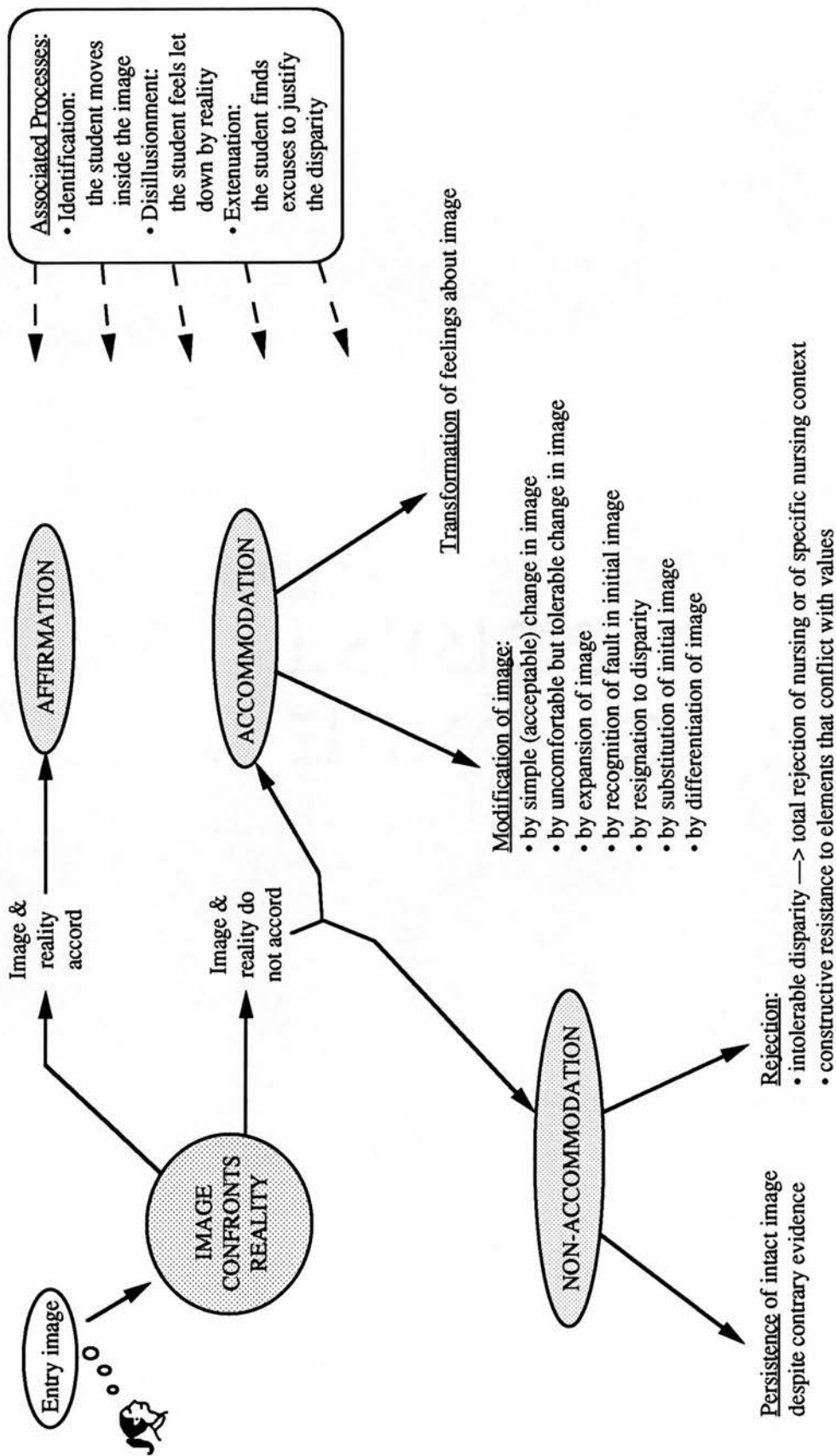


Figure 7.1

The processes of image development

when asked if nursing in their experience had been what they had pictured, responded in terms of whether they liked it or not. Carol, for example, answered, "Aye, it has, it's been great" (2). In other words, they tended to equate enjoyment or approval with agreement. This fits with Boulding's view (1958) of the importance of the individual's value scales in "determining the effect of messages" on the individual's image of the world. Because of this, it was necessary to inspect the interview data carefully to identify the detailed points of agreement and disparity, rather than relying solely on a student's "yes" or "no" answer to the initial question.

PERCEIVED AGREEMENT BETWEEN IMAGE AND REALITY: AFFIRMATION

"That rings a bell, yes, I still think that." (Ian 2)

When a student's entry image, or a component of it, was borne out by her experience of reality, a fairly simple process of affirmation of the initial image seemed to occur. In Boulding's scheme (see p14) this resembled either the first or fourth type of influence on the image: either the existing image was unaffected or it was made more certain.

Sometimes students indicated such affirmation as a general view; that is, they perceived that nursing overall was much as they had imagined it. Angela, for example, commented on her original descriptions of nursing and the good nurse, "I think I would still agree with everything I said" (3). In some cases, students found that it was their experiences in certain clinical areas only which agreed with their general images, as when Rachel said, "The medical and surgical wards have been what I imagined, definitely" (3). In such cases, the affirmation was qualified, and was associated with a differentiation between those aspects of nursing that had agreed with the student's image and those that had not.

There were numerous cases of components of students' images agreeing with the reality they experienced, though the students did not necessarily perceive that this was taking place. It might only be evident by an inspection and comparison of the transcripts from first and later interviews.

Typical examples of affirmation included both good and bad cases of agreement. Many students, for example, had expected to find satisfaction in helping people to get better, and went on to find that such experiences were indeed satisfying. Thus their image of nurses' finding satisfaction from patients' improvement was affirmed. On the other hand, some students found that their initial view that nursing included understaffing and overwork was true in reality, so this negative feature of nursing was affirmed for them.

In one sense, the latter example may constitute only a partial affirmation. It might be that the feature that existed in the initial image agreed with experience and in that sense was affirmed, but it might also be that the student's response to experiencing the understaffing and overwork gave the facts a dimension of subjective feeling that did not exist in the initial image. In other words, the image might not feel the same when it was being pictured from the outside, however realistically, as it did when it was being imagined from an insider's perspective.

Thus it seemed that an apparent affirmation might not function as such, or feel like affirmation, to a student. This phenomenon is discussed further later in this chapter.

"At first it didn't turn out to be like I pictured it, but now I think it is."

This statement illustrates a variant form of affirmation which occurred when a student perceived a disparity between an element of her initial image and her experience of reality, only to find that at a later point her experience agreed with her initial image. Eileen, for example, had said initially that in her image, nursing was not just a job. In her second interview she said, "Now I'd probably call it a job," but then in her third interview, she said, "I wouldn't call it a job any more, I'd go back to 'caring profession'." Thus she reverted to her original idea, feeling it had been affirmed after having been contradicted. The difference in this case was not between the initial image and the inside image, but between stages in the development of the inside image. These variations seemed to be related to how the incoming messages from Eileen's current experience fitted with her value scales, as referred to by Boulding (see p14). Messages contrary to a value held did not seem to be resisted, however, as Boulding suggested they would be, but tended to disillusion her and lead to a revision of the image, but when messages were congruent with a value held, her initial image was reinforced.

It is important to remember in this regard that the experience-mediated images evident from the students' final interviews in this study cannot be taken to represent a final version of their images as inside participants in nursing. Given the movement identified thus far, it must be assumed that the students' images would go on changing and developing indefinitely. This view disagrees with Horowitz's (1972) implication that there is a point at which completion of an image can be said to have taken place.

"I'd forgotten I said that, but I think I quite agree with myself there." (Julie 2)

Another variant of affirmation occurred when a student had forgotten an element of her initial image and yet described the same image. This was identified when a student was

unable to recall something about her entry image, but when prompted offered the same perception as if it were new, or agreed with it when it was quoted to her.

The existence of this as a separate process is suspect, because it is impossible to know whether a student truly had forgotten or lost a previous image, or whether it was stored in her memory but was just not readily available for recall. There were cases in which a student could not recount her earlier image but responded to hearing her words with a comment such as, "Oh, yes, I remember saying that." Such recognition would indicate that the old image was indeed still present as a memory of an image, though not necessarily as a current image. There seems to be evidence here of the mingling of memory and imagination images, as discussed by Morris and Hampson (1983), in that an apparently newly composed image contained elements that may have sprung from memory.

There were also cases in which students not only could not recall features of their initial images, but also did not recognize their own words when they were quoted to them, as happened with Julie in the example quotation. This would seem to indicate that the initial image had disappeared, and thus it seems reasonable in such cases to think of the agreement with the forgotten image as more than simple affirmation.

PERCEIVED DISPARITY BETWEEN IMAGE AND REALITY

When students perceived that the reality they encountered did not agree with the image they had held of nursing at entry, two broad types of process occurred as they faced the disparity. These can be identified as accommodation to the disparity and non-accommodation to the disparity. Each of these can be broken down into more specific processes.

Processes of Accommodation

MODIFICATION

"It hasn't been like I pictured it, but that's all right."

A simple form of modification took place when a student found that something in her experience of nursing did not agree with her initial image, but that it wasn't of any real significance to her. A fairly frequent example of this occurred when a student who had pictured nursing as being very busy found that there were times when it was not so busy. Such a disparity required nothing more than a response such as, "Oh, so it isn't actually busy all the time," and only required a simple adaptation of the image in order to accommodate to the disparity. In Boulding's terms (1956), this fitted with the

second possibility in his scheme, namely that the image is changed in a regular and well-defined way.

Another common example of this related to the degree of formality students encountered in the clinical area. Most of them had imagined a fair degree of formality and overt discipline, particularly in general wards, and they usually found that the reality entailed less of this than expected. Sarah described this:

I didn't think that general would be like as friendly as this ... I thought, well I'll have to get used to being called Nurse, but it's not been like that at all ... It's good, I like it this way. (Sarah 3)

Clearly, when a disparity was one which implied a situation that was preferred to that seen in the initial nursing image, acceptance of it was no problem.

Malcolm also indicated an adaptation to a different degree of formality, with a bit more besides:

[Surgical ward] was definitely less formal than I expected, it really fitted just about my picture, except it was a bit more hairy on the edge, you know, a bit more left hangin' about it. (Malcolm 3)

He seemed to rise to the challenge implied in this description of the disparity, and gave an account of enjoying the experience. Again the difference did not cause him much difficulty and he simply accepted it.

Some forms of modification were more complex.

"It's not like I pictured it, and it has taken a lot of getting used to."

Another form of modification occurred when a disparity did matter and was not so easily adapted to. Frances expressed this in her second interview when she said of her geriatric module, "I wasn't prepared for the actual dementia." The patients in the psychogeriatric ward to which she was allocated did not match the patients in her image of nursing, nor did the type of care they required fit her picture of the work nurses did. She then had to adjust her image of nursing and the nurse to incorporate something which was quite unforeseen and not particularly welcome. This type of process seems to resemble the third possibility of Boulding's scheme, whereby the structure of an image is changed in a radical way when such information from the world is received.

In some cases, the adjustment seemed to take place by the student's simply coping with the situation and adapting her image accordingly, if perhaps reluctantly. In other cases, it seemed that outside help or information had made the adjustment possible. This was the case for Gail, whose first encounter with ECT was alarming and unlike anything she had pictured in nursing. "It just looked as though they were going through agony (2)" she said, and she had difficulty reconciling her idea of what health

CROXLEY

professionals did for people with the apparent agony they were causing the patient receiving ECT. She was only able to adjust her image to this new element when she was provided with the knowledge that the patient wasn't aware and wouldn't remember anything, and once she had seen positive results of ECT, and she had now got used to dealing with ECT. Thus a values conflict had required resolution, and Gail seemed to need help to make the incoming information congruent with the values implicit in her nursing image.

"There's a lot more to it than I ever pictured."

In many cases, a student's initial image was modified by expanding to accommodate the disparity that occurred when elements encountered in experience had not been pictured in any form initially. This process seemed not to accord precisely with any of Boulding's options, but related to both the second and the fourth (see p14). That is, it involved what might be termed a regular and well-defined change in the image, and it also involved clarification of the image.

Hughes discussed this process in relation to medical students, and suggested similar notions of initial image and expansion of that image.

We assume that anyone embarking upon the road to medicine has some set of ideas about what the work (...) of the physician is, about what the role is, what the various medical careers are, and about himself as a person who may learn the skills, play the role, and follow one of the possible career lines. We assume also that (...) the medical aspirant's conceptions of all these things are somewhat simpler than the reality, that they may be somewhat distorted and stereotyped as among lay people. Medical education becomes, then, the learning of the more complicated reality on all these fronts. (1958:120-121)

Stein referred to such image expansion in relation to the socialization of the student nurse.

The world of her chosen occupation was more complicated than she had imagined. (1978:32)

Angela described how her image expanded in this sense.

What you first imagine, it's bound to change, because there's so many different things that have to be done that you don't even know exist before you start.
(Angela 3)

SCRIPT

In a few instances, it was arguable that this process did not entail a true disparity, since in some students' initial pictures there were things going on that they acknowledged they couldn't understand or see clearly because they were unknown to them at that point. In those cases, all that had happened was that the vaguely recognized

components of the picture had been clarified. However, the specific elements were not present in the initial image, so it does seem reasonable to treat their appearance as a disparity.

Angela said:

You get a picture of it before you go in, and naturally it's not the same, there's things you don't know, a lot o' things you don't know. (Angela 3)

She felt that the necessary adaptation of her image was facilitated by the fact that she had entered "with an open mind." That is, she was aware that new things would appear. This may be an example of what Gordon (1972) referred to as the fluid and flexible nature of some persons' imagery, as opposed to the fixed and rigid imagery that occurred in other cases.

In some cases, the expansion seemed to consist of an awareness of a variety of possible images, rather than just the one version that had first been pictured. Sarah, for example, had initially pictured a ward that was white, warm and busy. By her second interview her image had expanded to allow for other equally valid possibilities.

I still feel that here [in psychiatry], but like there are times I s'pose when you can see it as like really dark, if you've got one of the patients, or a nurse and a patient, sometimes you just see them two sittin' in a corner on their own, and it's dark, cause like the patient might be cryin' or somethin'. While there's the sort of warm group all havin' fun and everythin' in one, and then there's the other corner, and they're just two sittin' there. I think sometimes you can see it like that as well. (Sarah 2)

This process by which the image was modified by expansion was not necessarily problematic for students, and was often positive. As Carol put it:

It gets more interesting as you go on because there's a lot more things you know, and working in different wards and things, it's better, cause it's a lot mair interesting. (Carol 3)

"It's not like I pictured it, but that's because I had the wrong picture."

In some cases a disparity that was found to exist was perceived by the student to be the result of a faulty initial image, and thus the student saw herself as being largely the cause of it. This may be related to Gordon's comments about image flexibility (see pp14-15).

Lorna acknowledged such a modification. She had originally indicated that the nurse's greatest satisfaction would be derived from seeing improvement in a patient's condition. In her mental handicap module, she discovered that this was not where the most satisfaction was to be found. "I see that now. It's just seein' them happy, and havin' a laugh and everything" (2), she said. Lorna also experienced a later modification of her image, explaining that in her general modules, "The staff were

really nice, which was a big surprise. They were really nice, and the work was interesting" (3).

As in Lorna's case, it often seemed that students found types of nursing they had not expected to like to be better than they had pictured them. A number of general students found this to be the case with regard to their psychiatric nursing experience. Many of them had initially had negative images of psychiatric nursing, expecting it to be frightening or difficult to adapt to. Though not all of them enjoyed their experience, most did and some even decided they wanted to do a second training in psychiatry. Virtually all found that their image of psychiatric nursing required modification.

Another common modification related to the helping role of the nurse. Many of the students had indicated in their initial image that they pictured the nurse doing everything to help the patient, and they discovered that they had to modify this to an image of the nurse encouraging patients to help themselves. A common physical modification occurred when a student initially pictured all wards as large and open, and discovered that there were other types of wards as well.

In such cases, students simply accepted that they had been wrong. Mary Ann described this nicely, looking back at her earlier image:

It's different, I think. You're very idealistic and you think you're nae green, but y'are, fin you look back, you can see a difference. (Mary Ann 3)

This idea that their earlier images were unrealistically idealistic, and therefore destined to require modification, was quite common among the students. Julie, on having some of her early ideas read back to her, commented, "In a perfect world, it would probably be quite a good statement, but we don't live in a perfect world" (3). This seemed to illustrate the impression many of the students gave of having come down to earth in their inside images.

"It hasn't been like I pictured it, but you just have to put up with it."

Students sometimes modified their images by simply resigning themselves to the disparity when they encountered elements of disparity that they found hard to accept but about which they had no choice. It was as if they were loath to give up their ideals in circumstances where they believed those ideals should hold good, but they had to give them up for practical purposes. This could be seen as fitting with Boulding's (1956) description of the influence of values which are contrary to incoming messages, including the limited strength of such resistance to unfavourable messages.

One of the most common realities that required resignation of their initial images was the pressure of work within time constraints. Students often described the feeling

of not being able to give the standard of care they believed should be given, and the resulting feelings of not having done a good job. Pat described it in Sisyphean terms:

The knowledge that it's extremely unlikely that we'll be able to achieve that ideal is very frustrating and disheartening. It's like somebody decides to paint the Forth Road Bridge, it must be very frustrating for that man to get right to the end and go back and discover that the beginning is just as bad as the end was. (Pat 3)

There were many cases of experience with certain members of staff requiring students to go through the process of resignation. As Lorna put it, "Some of them just make you totally ill at ease. You just accept it. I just get on with my work and just ignore it" (3). Such alterations in the image, though disillusioning in terms of the individuals involved, did not necessarily affect the student's total view. That is, the student could retain her initial image, resigning herself to the fact that not everyone she worked with would fit the image, but retaining the view that it could or did still exist in reality in other contexts, particularly if she had had experience in such contexts.

Sometimes students had difficulty resigning themselves to the altered image. Mary Ann gave an account of a misfitting experience in a psychogeriatric ward.

It was a thought to go into my work. (...) I didn't actually confront the challenge then, I just sorta held my tongue and got on with it. ... I just wanted to leave and forget it. (Mary Ann 3)

Another feature of their experience that seemed to require students to resign a bit of their initial images was the observed role of the trained staff. They found that the patient care they had pictured nurses doing was often done only by students and nursing auxiliaries or assistants, while the trained staff had what Wendy described as "more of a sort of administrative job." She had resigned herself to the fact that she should enjoy her student days while she could, because that was the time during which she could do what she came into nursing to do. "The staff nurses don't nurse to the same degree the students do, and I'll miss that" (3). It was interesting that she was perceiving this loss before she had completed even half her training.

Boulding (1956) suggested that when resistance to incoming messages occurs as a result of conflict with the individual's value system, the individual either ignores the message or displays an emotional response such as anger or indignation. It could be suggested that resignation should be added to this list of possibilities.

"That picture's gone, and now I picture it this other way."

In a few instances, students' images were modified by apparent substitution, that is, the disappearance of the initial image and its replacement with another image. This resembled the "renewal" variant of affirmation in that the initial image could no longer be

found, but whereas in that case the new image was the same as the initial one, in this case it was different.

In one type of substitution, the student remembered having had an image which differed from the image as she gave an account of it at the time. Julie, for example, said in her third interview, "When I started, I was just thinkin' of bandaging people up and that, that was my picture of a nurse" (3). However, what she had described in her initial image of nursing was a sitting room scene with nurses talking to patients and listening to patients. (She had been the only student whose initial typical picture was not a scene in a general ward.) In her image of general nursing she described nurses as rushing about with things in their hands that she wouldn't know anything about yet. By the time of her third interview, she said that her typical picture of nursing was "just caring for patients, doing things that they can't do for themselves any more" (3). Interestingly, her new image differed from both the image that she described initially and the image she remembered herself having had initially.

With another type of substitution, the student simply did not recall her initial image, and did not relate her current image to it either as agreeing or disagreeing. Zena, expressed this in her second interview, "I can't think [laughs], can't really remember what I expected now, you know" (2).

There was also a type of near-substitution, when a student remembered the initial image, but almost without a sense of having perceived it subjectively. In Ian's third interview, he said

You get so involved in your nursing ... that you tend to forget ... (now) I just have the memories of the thoughts I used to have. (Ian 3)

Later in the interview, he alluded to the disappearance of his initial view when he asked me if I could tell him how his later accounts had differed from the first, because he "just wondered if there was anything you'd asked me and my opinion had changed" (3). In the first of these two extracts, he seemed to have a recollection of his initial perceptions, while in the second he seemed to indicate that he could not recall them.

It must be acknowledged that this sort of image substitution could be considered a process of non-accommodation rather than of accommodation, looked at in a certain light. That is, if the initial image has gone, and a different one has replaced it, can the image be said to have accommodated to the student's perceptions of experience? It is argued here, however, that it is impossible to know the answer to this, as it is impossible to observe the mental processes that take place, and it is reasonable to categorize substitution as a process of accommodation given that the student's perceptions of her experience in nursing have caused her to develop a new image which reflects that experience.

"In certain areas, it's like I pictured it, but in others it's different."

In some cases a student's image was modified by a process of differentiation, when the student recognized two or more images, one which had developed from her initial image, and the other(s) which were images of specific types of nursing that did not correspond with the initial image. The fairly common occurrence of this was not surprising, in that all but one student had had an initial typical picture of nursing which was of an adult general scene, and all students encountered at least four different clinical areas by the time of their third interviews. "Different wards are probably not what you expected", as Mary Ann said (3).

A fairly simple form of differentiation occurred in relation to the physical layouts of wards. Students who had pictured Nightingale wards had often worked in one or more, but had also had experience in modern style wards as well, and thus now carried two types of picture in their experience-mediated image.

Differentiation was particularly evident in relation to psychiatric, psychogeriatric and mental handicap nursing. Students used expressions such as "totally different" (Kathy 3) and "way off the track" (Tina 3). An interesting implication in some students' accounts was the notion that psychiatric and mental handicap nursing were not nursing, which seemed to be an especially strong form of differentiation. Tina, for example, implied this in her third interview during a psychiatric module.

(Here) I don't think you need to be a nurse as such, but you need to be a certain type of person. There needs to be something in you that wants to do psychiatric nursing. Well, not so much the nursing side, but it's more the psychiatric side of it. But I don't think you have to want to be a nurse. (Tina 3)

Julie referred to "being back to a real nurse again" after a mental handicap module. Valerie made the same sort of differentiation, saying, "I wouldn't say what we're doin' is nursin', it's more carin'. We're more carers than nurses" (3). Also present in this account is the implication that nursing is not caring, though to impute that meaning to Valerie's words may be over-interpretation.

TRANSFORMATION

"Some things I pictured are there but don't affect me the way I imagined they would."

The process of transformation related to a disparity in the feelings entailed in a student's image rather than the facts about what the image contained. In this sense, there seemed to be a strong element of role-playing in the students' inside images, as distinct from images that fitted solely into picture or description theories, as discussed in Chapter 1.

A fairly simple form of transformation occurred when a student had been dreading a certain type of nursing and then found she enjoyed it when she experienced it. This tended to happen particularly with general students and their psychiatric experience, and with non-general students and their general experience.

Some students experienced a transformation through a sense of achievement from coping with difficult experiences. Carol had dreaded the cardiac arrests she expected to occur in her medical module, but she found that dealing with them was a challenge that could bring a sense of satisfaction. Mary Ann had had to adjust to difficulties with staff, but she found that learning to cope with them had made her feel that she had gained in maturity. It was as if she had turned an undesirable disparity to a useful purpose.

The strongest instances of transformation were those that involved emotionally charged experiences. These operated particularly in the contexts of getting involved and dealing with death. Such examples have been cited in the sections discussing those categories, such as in the extracts from Carol's and Donna's interviews. They illustrate the way in which potentially bad experiences, as viewed in initial images, were transformed into good experiences. Just that process was described explicitly by Wendy in her third interview.

AK - Thinking of all the experiences you've had so far, the things you've done, is there anything that stands out as the best? The thing that you've enjoyed the most or that's given you the most satisfaction?

W - Care of the dying patient. [laughs] I never thought I would say that ... but it's nice, very rewarding ... it just seems to fall into place when you're caring for them. (Wendy 3)

Processes of Non-Accommodation

REJECTION

"It hasn't been like I pictured it, and I won't accept that."

When a student went through the process of rejection, she found the disparity intolerable. The result of this was an inside image that was incompatible with the student's expectations of what she wanted from her chosen occupation. In practical terms, this might mean that she either gave up nursing itself or resolved never to work in the field of nursing in which she perceived the disparity to exist.

There was only one student who discontinued training during the course of the interviews, and that was Zena, who left shortly after her second interview. She had indicated in that interview that she intended to leave and go to a secretarial job in another city. At this time she had had modules in geriatric and psychiatric nursing, and

though she had entered to do general nursing, she did not wait to experience either medical or surgical nursing. From her account, it was apparent that her geriatric module had been a bad one for her. Interestingly, despite the evident power of the influence of staff on the quality of students' experiences, it was not staff that had made that module a bad experience for Zena. "I got on fine wi' the staff," she said. She said she hadn't felt any satisfaction at all from the work: "I hated it." She had enjoyed aspects of her psychiatric module, though "sometimes it's pretty depressin'." Her own assessment of the situation was that the mismatch was between herself and nursing: "I think it's maybe just not quite what I'm for."

It would be difficult to conclude from what she said in her second interview that it was the disparity between Zena's entry image and reality that led to her rejection of nursing. However, an inspection of the transcript of her first interview offers some evidence in that direction, because it indicates that features of her entry image disagreed with the experience she recounted in her second interview. For example, she pictured a typical nursing scene as being in a ward that was bright and happy, and she pictured the good nurse as one who took time to sit and listen. In the event, she did not find either of her two wards happy places, though they were "OK at times". In her first ward, she encountered a situation of "too many patients and too few nurses", with too little time to talk to patients, and too many older patients who were difficult to communicate with. She described having quite good teaching support, with clinical teachers in both wards, and staff who were approachable and interested in teaching. Curiously, she indicated that she still fancied the idea of accident and emergency nursing, though she was not going to wait around to sample nursing of that type.

The disparities identifiable in Zena's case seem to have been no greater than for many other students. It seems most likely therefore that either Zena was not right for nursing, as she suggested, or there may have been other factors in her life that contributed to her decision. So although she was the only student to discontinue her training, she may not be the best example of rejection.

Tina was perhaps a better example of the process of rejection. She did not discontinue training, but she was already indicating doubts in her second interview: "I will do it for three years till I train, but I don't think I could be a nurse for the rest of my life" (2). She said there were just lots of other things she wanted to do. By her third interview, she was definite: "No way could I stay in nursing." She explained that "it just doesn't stimulate me enough mentally" (3). On follow-up, it was discovered that she did indeed complete her training, but never applied for a staff nurse's post and went on to higher education to do history or psychology.

Rachel had a somewhat similar response to what seemed to her the lack of mental stimulation in nursing: "I don't seem to use my brain enough" (2). She had not

expected nursing to offer less opportunity to “use her intelligence” than her earlier course in accountancy had, and she found herself craving “the satisfaction of seeing an actual account complete, correct.” This had led her to have doubts about whether she should stay in nursing, whether it would turn out to be as she had pictured it, but she did not act upon her doubts.

In their report, the Oxford Area Nurse Training Committee suggested that such disillusionment with the academic content of a nursing was likely to have implications for retention.

...entrants who came into nursing under the apprehension that they will be receiving a “scientific education” are twice as likely to withdraw as those who expect a basically practical training with some slight admixture of academic work. (1966:30)

They stated that those desiring theoretical study were “bad risks”. They had separately pointed out that “promotion literature frequently emphasizes the theoretical content of the course” (1966:30). Curiously, they failed to make the apparently obvious observations (1) that in such a case, the promotion literature was fraudulent, and (2) that the trainee’s perception that there is a gap between her expectations and reality is totally understandable. They merely comment on the fact that such a candidate is a bad risk.

It was not uncommon for students to report that they had thought about giving up training, and this usually did seem to be related to image disparities. As was discussed in the previous chapter, one of the major determining factors in students’ experiences was good and bad staff, and this was borne out with regard to these cases of near-complete rejection. Lorna spoke of “th’amount o’ times I wanted to leave” while working in a ward where the staff were difficult (2). Valerie had also thought of leaving from a ward in the same area, and going back to being an auxiliary, because it seemed as if “you’re better treated as an auxiliary than what you are as a student” (2). Kathy had similar feelings in a ward where staff had not made her feel welcome (3). She had gone as far as writing away about another job. These three students all went on to have positive experiences in later modules, and by the time of their fourth modules they had no thoughts of leaving. It could be argued that such evidence suggests that one aspect of the students’ value systems that was relevant was the notion of being valued themselves.

In cases where the process of rejection involved a specific field of nursing, the disparity could relate to the type of nursing as well as to staff. When staff had been the reason for a bad experience, some students indicated a desire to have another experience of that type of nursing so they could see whether they actually liked it or not. This happened with Ian in his second module; whereas in his second interview he said that

he really didn't like that type of nursing, from the perspective of his third interview, two modules later, he indicated that he'd like to try it again in a different ward.

In Carol's case, staff and type of nursing combined to make her thoroughly reject psychogeriatric nursing. It might have been possible for her to have felt differently if either had been positive; that is, had she found the type of nursing rewarding bad staff might have been more tolerable, or good staff might have enabled her to find satisfaction in an unrewarding type of nursing work. As it was, neither was present. With regard to the type of nursing, she said:

You were gettin' to the stage that you were just thinkin' all old people were like this, and you were beginnin' to hate old people, it was gettin' that bad. It was quite scary, actually, thinkin' that you could hold up this picture of old people bein' like this ... So I don't know, I mean, you've got to get people to work in psychogeriatrics as well, but ...

Describing what it was like to work in that context, she said:

You went out there, you left your brain and your humour at the door, you went in and did your work and went home again. (Carol 3)

The process of rejection in such a situation seemed inevitable. Carol's experience of psychogeriatric nursing was just too far from her image of nursing.

For Julie and Frances both, their rejection of a certain type of nursing was based primarily on the nature of the nursing itself. In Julie's case it was medical nursing, which she described as "the worst thirteen weeks of my life," because "I didn't feel like you were gettin' anywhere" (3). She went on to say that she preferred surgical, where people came in, had their operation, got better and went home. This seemed a particularly clear case of a mismatched image, because she was doing mental handicap nursing and found it rewarding despite the very slow progress residents made. In the case of mental handicap, her image was of slow progress, so the reality fit, but her initial image of general nursing was of seeing improvement, so there was a disparity between this and the reality in her medical ward.

In Frances's case, as in Carol's, it was psychogeriatric nursing that did not fit with her image, and she didn't find it rewarding at all.

I still don't understand the people who think that that is a good line for them to go into. I would never want to do that. (Frances 3)

In analyzing the data with regard to the process of complete rejection, it seems that the potential was highest when students encountered clinical situations that didn't offer the rewards they pictured in their initial image of nursing, and when the staff did not fit their image of good staff. Schedvin discussed this in relation to reality testing a career.

A student's image of his or her chosen occupation may be superficial or highly idealized and a process of reality-testing occurs as the course

proceeds. As a result, a student may realize that the prospective career is likely to be less satisfying personally than anticipated, or he or she may experience an even stronger negative reaction to aspects of the work. (1985:163)

On the other hand, it may be that serious disparities may be more likely to elicit complete rejection if they occur early in training, before a student has had the opportunity for affirmation and the positive processes of accommodation to take place.

"It hasn't been like I pictured it, and I won't settle for that myself." (or "I'm going to do better myself.")

Students' rejection of the disparity between their initial image and their experience sometimes took the form of constructive resistance. In this case, rather than completely rejecting nursing or a particular branch of it, the student held out against the disparity. This seems to fit with Boulding's (1956) description of resistance to incoming messages that conflict with an individual's value system.

Resistance might occur when a student simply held that a situation was not acceptable. If it was correctable, even if they did not see it corrected, they seemed to be able to resist rather than reject. That is, they could say "That just isn't good enough," and know that it was possible for it to be better, if they didn't see it as inevitable in their inside image of nursing. Rather than rejecting the new image, they resisted incorporating the disparity into the image. Tina's account in her second interview suggested this when she said

I've seen people, staff nurses that aren't right, in my opinion, that are just not meant to be nurses ... they just don't fit in. (Tina 2)

Thus she resisted accepting such staff nurses into her real image of nursing: they didn't deserve to be in it, and nurses didn't need to be like that.

For some students, resistance meant doing something active in the present to remove the disparity from their experience of reality. Helen, for example, and three of her fellow students decided to complain about the situation in a particular clinical area where the policies and the attitudes demonstrated by staff did not fit with what they expected, and they succeeded in instigating changes. In Donna's case, when she found the disparity intolerable in a particular area, she became assertive on her own behalf rather than accept it.

For other students, resistance meant that they resolved not to be a party to the conditions of the disparity; their action was in the hypothetical future. Gail hinted at this when she described the behaviour of a sister that did not fit with her idea of how things should be, a sister who "shouted at students in front of staff and patients." Gail stated,

“I would take them aside, which is what she should be doin’, not humiliatin’ them” (3).
Mary Ann was quite clear about her resistance:

I would only like to work there if I was in a high enough position to have my ward run my wye ... just the things that went on, I wouldn’t’ve stood for. (Mary Ann 3)

Ian, too, had clear ideas of how he would run a ward when he had the chance, making up for the shortcomings he saw in the reality he had experienced.

It seemed that resistance could be a constructive and positive form of rejection, when students encountered features in nursing that disagreed with their images and conflicted with their values.

PERSISTENCE

“It hasn’t been like I pictured it, but my picture is still correct — I just haven’t been to the right experience yet.”

The process of persistence was a mechanism by which students retained their initial images intact despite contrary evidence in their clinical experience. In this way they could avoid adapting their images to disparities that existed. This fits with Boulding’s suggestion that the power of value systems to enable images to be maintained should not be underestimated, in particular his statement that “we only get along in the world because we persistently disbelieve the plain evidence of our senses” (1956:14).

Persistence was particularly common in second interviews among students who had not yet had medical or surgical modules, or who had not yet had a module related to their chosen specialty. When Frances was asked in her second interview whether her experience so far had been like her picture of nursing, she answered, “Well, of course I haven’t done any general nursing as yet.” In other words, she didn’t expect her first two wards to match the picture, because she knew they weren’t what she had pictured. Becky (2) put the same point the other way round: “I’m still not sure if [my picture] has changed, cause I’d never really thought about psychiatric nursin’ before” (2).

In Angela’s case, her picture of a big open ward persisted as her typical picture although her first two wards had both been modern with small rooms. She recognized that they did not fit her picture, but instead of her picture altering, she just felt she hadn’t come to it yet (2). For Wendy the same applied to wearing uniform. She had pictured nurses in uniform, but in her psychiatric ward the nurses wore “civvies”. This did not disrupt her image, because she only expected it to apply “in terms of a general ward”, and she hadn’t been to one yet (2).

Rachel was withholding her judgment of whether she liked nursing until she discovered whether her general modules fitted her image or not. “I think I’m slightly

dissatisfied at the moment," she said, "but I realize that I haven't really seen the side of what I've expected to see." Later she said she was apprehensive looking towards her general modules "in the fact that they're hopefully going to make me feel more satisfied, make me feel a bit fulfilled" (2). It was as if she was saying that her dissatisfaction so far was all right, because she hadn't expected to be satisfied or fulfilled yet, so the risk of disappointment hadn't really existed yet. However, that became a possibility once she was in the area of nursing that she did expect to fulfil her image.

Persistence was less evident in third interviews than it had been in second interviews. This was not surprising, as by that time all the students had had experience in general nursing, which is the type of nursing most had pictured in their initial images. When it did appear, it tended to relate to a student's image of a specific feature of nursing she hadn't encountered yet, either a particular procedure, or caring for a certain type of patient. Lorna's picture of the nurse's response to death, namely that it would be "awful hard" (1), persisted even though her image appeared to undergo a transformation in this respect (3). Although she had found she could cope well with death, she persisted in believing it would be bad when the real thing came along. She discounted her experiences to date on the grounds that the deaths had been expected, and persisted in picturing "the worst" when sudden death would occur.

An entertaining instance of persistence occurred with the two students who had been intrigued by ambulances, Sarah and Rachel. They had both mentioned this in their initial interviews and continued to have the same pictures in their second and third interviews. Neither of them had any accident and emergency experience during their first stage of training, and their images of the drama and excitement of that type of nursing persisted, untouched by the multitude of alterations taking place in other components of their initial images.

The phenomenon of persistence has also been identified by Raeburn (1990) in relation to the image of variety in nursing. She found that male students early in their training believed that variety was one of the key features nursing had to offer, and this belief persisted even when a student's only experience might have been in a geriatric ward with a daily routine that never varied and patients who never changed. The students seemed to retain their belief in the existence of the anticipated variety by believing it to still be just over the horizon. This notion of variety and its persistence in students' images was also present in this study, though less evident in third than in second interviews. It should be noted that none of Raeburn's interviews took place as late in training as the third interviews in this study did.

Stein found this phenomenon among second-year student nurses in relation to another aspect of their images of nursing, involving their view of the nurse's role.

Following orientation in the School of Nursing, they found out that nursing practice differed from their expectations; but they still had a layman's image that did not include the idea of becoming a leader in nursing. The majority of sophomores saw themselves as physician's helpers. They emphasized various aspects of nurturance and "helping humanity" until well into their sophomore year. (1978:25)

From the evidence in the present study, it seems as if the process of persistence could be used by students to avoid having to alter their images in the face of perceived disparity, but only rarely did it retain this function beyond the first year or so of training. In her study, Stein found that the students began to lose the image aspects cited above as they progressed through their third and fourth years of training (1978:25). (The students in Stein's study would have had less exposure to clinical nursing during their first and second years than did the students in the present study, which may account for the apparently longer period of persistence.)

Mackay has suggested a practical use for students' hanging on to their initial images despite contrary experiences.

The hope that the next allocation will be a 'good' ward makes negative experiences more bearable. (1989:33)

It may be that by retaining a good image element despite conflicting evidence, the hope for improvement is easier to retain. If a student alters her image to accommodate bad evidence, that would seem to destroy hope for a better experience in the future.

RELATED PROCESSES

Alongside the processes discussed above, by which students' images correlated with reality, or by which they accommodated or did not accommodate to disparity, three other processes were identified: identification, disillusionment, and extenuation.

IDENTIFICATION

"I see myself inside the picture now."

Identification was associated with the total complex of processes already discussed and accompanied the development of students' images in a variety of ways. It was the process by which they grew to see themselves as moving into the image.

In initial interviews, students tended to describe their images as something they were perceiving from the outside. They often seemed to project themselves inside the picture, but still described it as if they were looking at it (and themselves) from the outside. A student might, for example, answer a question about what she pictured nurses doing by describing what she pictured herself as a nurse doing, but she

nonetheless described the picture from an observer's perspective. This seemed to fit with the notion of a role-playing theory of imagery, except that it did not convey the subjective perspective of the role-player. In later interviews, students described the image from a vantage point inside the picture, though the degree to which they felt comfortable or felt a sense of belonging within the context varied between students and between contexts. Between the outside and inside perspectives was a sort of mid-point at which the students' were acquiring information about the real world of nursing but were not yet within it, as has been described earlier.

The notion of nurses having feelings seemed to be a part of the change that came about in students' images as they became part of nursing themselves. This applied to situations of "getting involved", about which some students changed their view from "you should never get involved" to "you can't help getting involved". It also applied to the reality of the fact that sometimes the nurse would act on her feelings rather than always being totally controlled. Helen, for example, had said in her initial interview that a good nurse would always be patient, but when asked in her second interview whether she still had that picture, she said, "No, you have to lose your temper sometimes." Having worked with children when they were "playing up", she found that the ideal image of total patience was unrealistic.

Another type of evidence of identification was found in the students' accounts of describing themselves as nurses. Gail was typical of many when she said, "I like just sayin' that I'm a nurse, because I like bein' a nurse, it's like doin' somethin' that you really want to do and bein' able to tell people" (2). Sarah seemed to perceive a disadvantage in relation to the expectation that nurses should all be models of perfect behaviour. "You feel like, well, I'm a nurse, so I'm not Sarah any more." On the other hand, she quite liked being identified as a nurse, and told of being asked to help someone injured at a party.

The way somebody grabbed me and said, 'Are you a nurse?', I just felt like I'd got it written across my forehead or somethin'! But things like that, it's quite funny, well it's quite good. (Sarah 3)

Only one student, Julie, said in her second interview that she would not call herself a nurse but a student nurse. By her third interview she was saying, "I feel quite proud to say 'I'm a nurse'." It did seem that the identification that was taking place among the students was as nurses, not as students.

Despite the good feelings about telling people they were nurses, a number of students described problems in this regard. For the females, it related to the sexpot public image, and some of them, such as Eileen (2), did not tell young men they met socially that they were nurses. One of the male students mentioned the well-known stereotype related to males in nursing, namely that they were likely to be homosexual. He said he

wasn't worried and just laughed it off when it was mentioned in a social context. As he had no worries about it himself, he did not feel defensive about it.

Changes in social life were part of the practical side of identification, with many students telling of losing touch with previous friends and socializing exclusively with people from nursing.

Some students gave accounts of adopting views that came from understanding things from the inside, views that differed from those of the ordinary public. Wendy was annoyed at people's reaction to someone from the psychiatric hospital, now that she had worked there and knew that psychiatric problems could happen to anyone.

I really felt like saying, "Well do you mind? You or I could end up at [psychiatric hospital]." I really thought it was sort of thick views that people have. (Wendy 3)

Students often recognized the changes that were taking place in themselves as they identified themselves as nurses. "I've got a lot more views about certain issues," Carol said, and "I do tend to take things much more seriously now. My mum says to me, 'You're growin' far too old, far too quick!'" (3)

Becker and Carper alluded to the place of self-image in describing the development of identification with an occupation.

It is through (...) changes in participation in organized groups and transformations of various aspects of the self-image, that occupational identifications develop and change. (1970:201)

There was also, of course, evidence of failure of the identification process, as when students thought of leaving nursing, or when a student such as Eileen altered her image of nursing to the point of seeing it as "just a job" (2).

The process of identification was tied up with many features of the themes discussed in the previous chapter, particularly becoming a nurse, and the belonging aspects of settling in as a student.

DISILLUSIONMENT

"I feel let down because it hasn't been like I pictured it."

Disillusionment acted as a type of inhibitor when an unacceptable disparity was perceived as a student's initial image came up against the reality of experience. Not all disparity was negative, of course, and when it wasn't, there was no disillusionment. Further, not all disillusionment led to non-accommodation, though it tended to make accommodation more difficult. It should be noted, however, that accommodation might not always be desirable. A student might suffer ill effects from having accommodated to a disillusioning disparity. Thus it could be argued that the best outcome for

a student (the most desirable or comfortable inside image) was likely when there was no disparity between the image and the reality, or when accommodation did not involve disillusionment.

Many examples of disillusionment can be seen in the foregoing discussions of themes and processes, and it is not the intention here to reiterate them. In general terms, students expressed disillusionment when staff behaved badly towards them, when the work did not turn out to be as interesting or rewarding as they had pictured it, when there wasn't enough time to give the standard of care they wanted to give, when they saw ward staff giving care they perceived as sub-standard, when they found that there were inadequate mechanisms for student support, and when they were given no recognition for their work.

In some cases, students actually expressed their disillusionment in explicit terms: "That's the things that get to me, the frustratin' things, like if you know something would be possible but there's just not the facilities for it" (Malcolm 2); "We never got any teaching by the staff, and that was really a disappointment" (Donna 2). In other cases, it was in the tone or connotation of what they said: "When you're a student nurse, you're just another pair of hands or a dog's-body" (Tina 3); "I think I am enthusiastic, but I just can't be in that ward. When I'm there, it's just, get on with it" (Eileen 2). In common with Becker and Geer's finding in regard to medical students (1958:51), it was noticeable that students' disillusionment in the present study was not with patients.

One feature of nursing as they perceived it seemed to give the students particular cause to feel disillusioned, and this was the role of the qualified nurse. Many made the observation that they had come into nursing to care for patients, but that trained staff seemed not to do much of that. Ian and Wendy both highlighted this:

One thing I'm disappointed with here is, like the staff nurses don't seem to get as involved in the nursing work as we do, they're always answerin' a phone or doin' a drug round and, I dunno, if I'm goin' to be a staff nurse, and it's nursin' I'm wantin' to do, so ... is this what staff nurses are goin' to be like all the time? (Ian 2)

The only thing I don't like about it is, it seems to be once you're a staff nurse, it is admin more than patient contact, and that's a bit depressing to think that's what you're trainin' for, as [charge nurse] said a few times, enjoy your time as a student, he says, because you'll never be in closer touch with the patients once you're a staff nurse. (Wendy 2)

This is similar to a feature pointed out by Broadhead in relation to medical students, namely the contrast between the service ideals with which they entered their medical education and the professional ideals of the training programme, and their need to reconcile the two as they progressed through their transitional status on the way to becoming doctors (1983:108).

EXTENUATION

"It isn't like I pictured it, but that can be explained/excused by ..."

In the accounts of several students there was evidence that a process of extenuation was taking place as a type of support to the accommodation of their images to disparities they perceived in the experience of nursing. In other words, they identified mitigating circumstances which lightened the seriousness of an otherwise unacceptable disparity. This process might also have been called "justification" or "rationalization", as it refers to cases in which students found excuses they could believe justified otherwise unacceptable disparities.

One of the excuses that was found for a number of shortcomings was the shortage of staff and overburden of work. This excuse was suggested by Pat, for example, to justify the inadequacy of the teaching of students by staff in a particular clinical area.

Another excuse offered by students on behalf of staff, both for poor teaching and for too little participation in patient care, was that staff had so many other responsibilities. Rachel provided such extenuation in the case of a particular sister.

You didn't see an awful lot of her, I must admit you didn't, but then again, there is a lot of paperwork, I mean, you hear an awful lot of folk moanin' about them, but then I think, well they have got an awful lot of paperwork to do, and there's a lot of things that we don't know about they they've got to do. (Rachel 2)

Several students mentioned an excuse for staff who did not do as well as might be hoped to make students feel welcome and help them settle into the ward. Gail provides a good example:

I think the staff is at a disadvantage as well, because they know you're only there for thirteen weeks ... they see so many staff, students and pupils comin' through that it's just a continual process, really. And they keep leavin' And they keep havin' to go over the same things all the time. So I don't suppose it's entirely their fault. (Gail 2)

Students in Melia's study offered similar accounts of excusing the less-than-ideal behaviour they observed in trained staff. She suggests that this is a necessary coping mechanisms students employ.

The students (...) are in need of some means of rationalising their experiences in order to cope with their day-to-day encounters and get through their training. (1983:26)

Melia's students' accounts contained many elements that were uncomplimentary to permanent staff, but the students indicated that "they did sympathise with the permanent staff's position"(1983:27). Simpson has referred to this aspect of occupational socialization, noting its relationship to the values an individual attributes to an occupation.

She suggests that the attributed qualities transform the occupation so it embodies the values the individual has attached to it, and experiences are then seen and felt from the perspective of those qualities (1979:39).

The evidence in the present study seems to show that students varied considerably as to how much extenuation went on as their images developed. At one extreme, Oliver seemed to allow no extenuation at all.

To be a good and competent nurse, there is no reason why you can't (spend time with patients). There is all the time in the world, for instance, I know, to spend time nursing and fulfilling a management role. That isn't a very valid argument, if it is used by them. There is time. (Oliver 3)

Wendy was at the other extreme, apparently willing to find excuses for all sorts of things:

For staff inattention to students:

I think [the staff] must get really cheesed off with students comin' in and out all the time. (Wendy 2)

For staff nurses who didn't teach:

They were newly qualified, and I think they were just finding their feet, so it's understandable that they didn't have the time. (Wendy 3)

For a clinical teacher who cancelled repeated appointments to work with her:

It was just circumstances. (Wendy 3)

For not getting to do any of the interesting jobs, when there were more senior students in the ward:

Obviously they had to do just as much as they could before they went. (Wendy 3)

The process of extenuation seemed to provide a mechanism by which students could retain some of the ideals in their nursing images and yet adapt them to a reality that fell short of those ideals. The degree to which a student used this process may have had implications for how successfully she coped with the real world of nursing, either for better or worse.

Comment on the Processes

Comparison of students' accounts from their first, second and third interviews provided evidence as to the nature of the processes that occurred as students' images developed during this time, as has been detailed above. Theories of imagery discussed in Chapter 1 were useful in interpreting this data, but there seemed to be aspects of students' image development that were not adequately accounted for in the theoretical models offered. In particular, the distinction between picture theories, description

theories, and role play theories did not seem to reflect the depth and variety of the students' imagery. Many elements of their images of nursing had aspects of all three, and in addition, there seemed to be dimensions that none of the three allowed for sufficiently. The sounds, smells and feelings of images were expressed by many of the students. Although it could be said that these elements could be described, the notion of description does not seem a powerful enough way to categorize them. It might also be suggested that, particularly in their inside images, role-play theory might incorporate these elements, but this does not seem to place sufficient emphasis on the individual's perception of response, as distinct from the perception of playing a part.

Perhaps the images identified from the students' accounts might be usefully categorized within a multi-sensory theory of images. Whereas the individual theories can account for specific aspects of the students' images, a multi-sensory theory could better imply their wholeness and the interrelatedness of their component parts.

Chapter 8

CONCLUDING DISCUSSION

In this chapter, selected elements of the students' images of nursing and the developmental processes they underwent are highlighted. The notion of the move from an outside to an inside perspective from which students viewed their images is central to the discussion. A number of implications of the findings are explored. Finally, avenues for further research are suggested.

A Note on Limitations

Prior to such a discussion, it is pertinent to reiterate the limitations of the study, in order to keep the findings in perspective. The study was small, the student subjects numbering only twenty-four. Saturation of the categories identified during analysis cannot be assured, though as was demonstrated in the preceding chapters, a coherent scheme of interrelated theoretical themes and processes was generated.

The students interviewed cannot be assumed to be representative. They constituted a virtually mono-cultural group, as all were Scottish apart from one English student. As described in Chapter 4 (see pages 53-54), on a number of measures these students appeared to be fairly typical of the cohorts from which they were drawn. With respect to the types of training they were pursuing, however, they constituted a skewed sample, in particular in the overrepresentation from mental handicap training. (It is impossible to know whether this distortion had any meaning, particularly given that the students' images of nursing were nonetheless overwhelmingly of general adult nursing.) This resulted in part from the voluntary element in the selection of interviewees, and in part from the pursuit of emerging conceptual themes. It should also be noted that these two angles of the study method were at times at odds with each other. That is, although there were attempts to seek specific types of interviewees in pursuit of the emergent themes, the voluntary nature of the participation did imply a degree of restriction.

The students were found to be atypical in another respect, namely their rate of completion of training. In the total group of students that entered Scotsburgh College during the twelve-month period that included the three relevant intake groups, the discontinuation rate was approximately 14.9% or 13.4%, depending on whether the calculation is based on all students who left the college before completing or only those who left nursing altogether, as a small number transferred to nursing courses elsewhere. Among the twenty-four students in the study, only Zena did not complete her training, giving a discontinuation rate of 4.2%. The other twenty-three students all

passed their registration examinations and completed their training. Again it is impossible to know whether the students' atypicality on this measure is relevant to the research topic under investigation. The possibility has to be considered that the interviewees may have been more academically able and/or more committed to nursing than were their classmates, or even that participating in the research itself may have influenced their likelihood of completion.

Another limitation of the study is that it was conducted by a single researcher. This has at least two broad implications. First, the time and energy that could be spent on the research within any given period of time was circumscribed by the researcher's other responsibilities. At times the formal analysis necessary for true constant comparison could not be carried out concurrently with the data collection, though informal analysis was continuous. The second implication arose from the fact that the planning, data collection and analysis were all carried out by a single individual, and thus the possibility of the researcher's influence existed at virtually all stages of the process. On one hand, this may have contributed to the coherence of the study, while on the other it implies potential bias. In such a qualitative study, as was discussed earlier, the notion of the researcher's participating in the process in the first person is an integral part of the research and should arguably not be considered a flaw in the process. In addition, the possibility of bias was ameliorated to some extent by the scrutiny of academic supervisors and others with whom the work was discussed during the conduct of the study. However, as there was no formal co-judging of qualitative categories, it should be remembered that the analysis offered represents the interpretation of the researcher alone. Readers may judge for themselves, on the basis of the evidence provided, whether or not this interpretation is convincing.

It should be similarly noted that there are limitations consequent on the method of data collection. That is, the data were collected from a single source and by a single primary method. It is also true, however, that the nature of the phenomenon under study is such that no other means of gaining access to relevant data existed, though the scope of collection could be enlarged.

Along with a recognition of the above limitations, it should be remembered that the purpose of the study was not to provide grounds for generalization or prediction, and the findings are not offered in that vein. They are offered as potential ways of better understanding student nurses' images of nursing.

Discussion

In one sense, the perspective of a student entering training is not that of a total outsider. Such a student has already begun to identify with nursing to the extent of choosing it as

an occupation to pursue. For students in this study, this choice was sometimes a qualified one. At least one decided it was not the most suitable choice for her. A number saw it as a temporary choice only, in that they intended to go into some other field of work either following their training or after a short period of staffing. A few saw nursing as ultimately a secondary choice, in that they intended it to take second place to marriage and children. However, all who had selected it had at least made a choice to spend some time within the world of nursing.

Given this proviso, it was clear from students' accounts that they moved from a vantage point of virtual outsider, through that of increasingly informed outsider-to-be-insider, to that of insider in the world of nursing. As their vantage points altered, their images developed.

One nearly constant element was the image of nursing as general nursing. This was clear in initial interviews and remained the case in later interviews. Students were often reluctant to pass judgment on whether nursing as they experienced it was as they had pictured it until they had had experience in an adult medical or surgical setting. Students who responded that nursing *had* been what they had pictured tended to illustrate this with examples from general nursing. A number of students doing other types of training indicated that the field they were going into was not nursing as such, but was something different — “caring”, as one suggested.

This is a particularly salient finding in view of the fact that the college under study required students to select their field of nursing at the point of application. It appeared from the data that students often did not have a clear idea of what the different branches of nursing entailed. In addition, there seemed to be considerable difference between *knowing about* nursing, even when the image was found to agree with reality, and the *knowing* that was acquired through experience. The implication of this is that even when students have adequate information about the different fields of nursing, they cannot *know* nursing until they have experienced it, and thus the notion of making an informed choice is a nonsense until they have had experience in the fields among which they are choosing. This situation should be ameliorated in the new Project 2000 training schemes to be implemented throughout Scotland in the autumn of 1992. Within the new schemes, an 18-month Common Foundation Programme should give student nurses a taste of each of the nursing fields, and their choice will not be made until this experience has taken place.

Another element of students' images that remained constant between their initial images and their experience-mediated images was the notion of helping. Before experience, helping formed an integral part of their images of nursing, and this was one of the primary reasons for their wanting to do nursing. In describing their experience-mediated images, helping still had a high profile but had acquired greater complexity.

For example, feeling they had helped and seeing the results of helping constituted part of the good of nursing in their inside images, as it had in their entry images. Factors that inhibited their ability to help, such as too little time or too few staff in relation to the effort needed to give a high standard of care, constituted part of the bad of nursing. It seemed that in this sense, the good in a student's inside image was "nursing as it should be", while the bad was "nursing as I may have experienced it, but as it should not be."

Thus although the bad was part of nursing as the students encountered it, it was perhaps not fully accepted as part of their images of nursing. In the previous chapter, such elements have been discussed as either being accommodated or not accommodated in the students' inside images. Failure to accommodate to aspects of the bad can be seen in at least two lights. If a student's image is incapable of accommodating to such disparity, she may reject nursing as an occupation. This represents an undesirable outcome, in that it is a loss to the profession of a potentially positive member. On the other hand, a student's rejection of the disparity might engender in her a determination to change things, or not to be a party to the bad herself. This could be seen as a desirable outcome.

Underlying this analysis is the view that the good as it appeared in the students' images of nursing was, in fact, good. This does not seem an unreasonable view. An examination of the students' initial images of the good does not reveal anything that was either inappropriate or excessively idealistic. On the contrary, the positive traits they saw as being characteristic of nursing were easily recognizable as being present in rewarding nursing experiences. The same can be said of the students' images of the characteristics of the good nurse. It can therefore be suggested that their initial images in this regard, while naïve, imply desirable attitudes in candidates and novice nurses. The arrival of new members who repeatedly provide a fresh injection of such ideals may be healthy and necessary to the well-being of the profession.

This interpretation might suggest that there is room to question the wisdom of trying to project too professional an image of nursing in recruiting material. If nursing rejects the old-fashioned images as being irrelevant to the public image and status today's profession desires, perhaps it risks cutting off one of its major sources of essential ideals, if the new recruitment strategies fail to attract candidates with old-fashioned ideals. On the other hand, of course, if nursing advertises itself as an occupation that provides its members with the personal satisfaction that results from caring for people, it then has a responsibility to fulfil that claim by providing that satisfaction, or it could be accused of false advertising. Glaser and Strauss allude to this issue:

...recruiting may entail the proffering of a passage to the agent or passagee. A story, ideology, or line about the passage is proffered, and on its basis the person tends either to accept or reject entry to the passage. Proffering is designed to help a candidate discriminate between what is and what is not real about the passage. What is actually proffered, however, may be ideology or myth designed primarily to persuade recruits. Or it may be truth or counter ideology to correct various dimensions of generally known ideology, but this effort still is made to persuade. Mixtures of fact and fiction are usual. Thus the recruit, who does not believe everything, may not know how much and what to believe about a passage. (1971:61)

One aspect of the students' experience-mediated images provides cause for concern in this regard. While many aspects of the satisfactions that existed in the students' entry images were retained in their inside images (the proffered story was found to be truth and not myth), it was also the case that by that time there seemed to be a division between their images of nursing as they were practising it as students and nursing as they saw it practised by the qualified staff. In this sense, they were insiders only to a transitional status in the passage to qualified nursing. Though becoming increasingly informed about it, they were still outsiders to qualified nursing. As has been described, they were discovering that whereas student nursing entailed the caring-for-people that had existed in their entry images, nursing as practised by qualified staff appeared to entail much less of it than they had imagined. As indicated, this tended to be a cause for disillusionment. It could be suggested that in this regard nursing may fail to provide a full measure of the satisfaction pictured as a central part of the good in student nurses' entry images. Students in this study indicated that they were beginning to imagine the loss of this source of satisfaction once they were qualified.

Despite this split that appeared in the students' images, it was evident that they saw themselves as having become members-of-nursing as distinct from having become students-of-nursing. They saw themselves as perceiving the world of nursing from inside, rather than as being in a position of preparing to enter it. Thus their position differed both from students in other fields who were studying subjects that did not confer an occupational status, and from young people who took on a job that was just a job.

In the students' images, both at entry and after experience, they perceived nursing as something that one joined and that entailed a form of belonging that set one apart from others who did not belong. This feature was similarly found in Raeburn's study, in which students described "a world peculiar to nurses, (...) like being a member of a family, and it was something special"(1990:92). In the present study, joining the world of nursing seemed to occur in stages. There appeared to be certain phenomena that functioned as initiation rites or rites of passage. These included such precise events as giving the first injection, facing the first death, or seeing the first body. They also

included less precise experiences such as being recognized by patients and families as nurses, this being evidenced by being thanked for their care or being remembered at subsequent encounters. Many of these phenomena had featured in students' initial images as part of what might be described as the folklore of nursing. They featured again in students' inside images, and the students were building up their own repertoires of stories of nursing experience. Thus their personal tales of nursing were joining those of the community of nurses, reinforcing their sense of belonging and their image of nursing as a special world.

With regard to nursing as people-work, it was evident that one aspect of students' initial images that was not disappointed was the place of patients in the image, similar to the medical students in Becker and Geer's study of *The Fate of Idealism in Medical School* (1958:51). Superficial aspects of entry images, such as patients being in their beds, were not always borne out, but the central place of patients as providing satisfaction was still strong in inside images. Students had pictured working with people as an integral part of nursing, and as part of the good, and indeed they found working with patients reinforced their images in this respect. However, the place of staff as people underwent major alterations in their images. Staff constituted a source of differentiation in their images, as some were good and fitted with the imagined satisfaction of working with people, but some were bad and not only did not enhance satisfaction but were the cause of unpleasantness and disappointment.

This particular potential disparity between initial images and experience was problematic for students. Whereas their images displayed considerable resilience and adaptability over time with respect to many components, students seemed less able and willing to alter their images to accommodate staff behaviour and attitudes they considered inappropriate. It could be postulated that the strength of resistance to this disparity was due to the conflict it represented with values the students held personally and/or attributed to nursing in their initial images. As W B Glaser has indicated,

... the problems of a self-conscious and organised occupation arise from the members' (...) feeling that they have failed to realize prized values. (1966:1)

The data indicated that there were clear links between students' values and their reasons for wanting to go into nursing, so it seems logical that evidence contrary to their values would be unwelcome and not readily incorporated into their images of nursing.

A concomitant of the good staff/bad staff element of students' images was the fact that the quality of a clinical experience seemed to depend at least as much on a student's perceptions of the staff as on the type of nursing, and not at all on features such as the modernness of the clinical environment or the standard of facilities. In respect of the

students' learning and personal development, the predominant impact of staff suggests questions about the relative value of experience with particular types of nursing care as compared with the quality of the experience. Melia (1984) has challenged the value of the constant change of clinical placements, on the grounds that it fosters a transient approach to nursing work. From the present study, its value might be challenged on other grounds as well. Implicit in British nurse training programmes is the assumption of a need for exposure to varied types of clinical experiences. However, it might be that extended experience in one clinical setting with good staff support, regardless of the type of clinical nursing, might be of more value than several shorter varied experiences, if some of those settings did not offer an interpersonal context conducive to the student's learning and comfort. Clinical areas as learning environments have been explored in a number of studies, and positive and negative characteristics have been well described (e.g. Orton 1981, Fretwell 1982, Alexander 1983, Gott 1984, Reid 1985). However, the need for exposure to a specified variety of clinical contexts has seldom been questioned as essential to a student nurse's experience. Perhaps this warrants rethinking during the process of instituting new schemes of training for Project 2000.

As was alluded to above, there were other aspects of disparity between students' initial images and their experience that did not cause them great difficulty and were more easily accepted into their experience-mediated images. This was at least partially the case with the gap they perceived between the nursing of the college-projected image and the nursing they encountered in clinical areas. Differences which they did not perceive as negatively affecting patient care or their own well-being seemed to be easily accommodated. As has been described, a number of students indicated that the presence of a college ideal and a clinical real version of nursing was not only understandable but desirable and useful. Their awareness of the difference, and their insight into its capacity for explanation, might suggest that in the perennial discussions of the theory-practice gap in nursing literature, students' ability to adapt intelligently and safely is too seldom recognized. However, two caveats must be added to this observation.

First, there was a particular aspect of the gap, namely the omission gap, that did present problems for students. They found it especially difficult to cope with clinical experiences they had had no preparation for — experiences for which, it might be said, they had no image at all. These included unanticipated types of patients, such as demented patients, or skills they had had no opportunity to develop or even contemplate, such as dealing with an epileptic seizure or the administration of blood. In general, their responses to this seemed eminently reasonable. For example, the students who bemoaned the lack of preparation for dealing with demented patients had been assigned to psychogeriatric wards, where it was a foregone conclusion that they would

encounter such patients. Similarly, students who wished they had had teaching to prepare them for epileptic seizures or blood transfusions were in modules in which it was likely they would be faced with such necessities. This omission gap could be seen as a complement to the second form of non-integration in training programmes identified by Alexander. She found that students perceived a lack of integration when "theory was not followed by relevant ward practice" (1983:207), whereas the omission gap identified in the present study occurred when practice was not preceded by relevant theory.

The second caveat applies both to the gap specifically and to the students' image disparities in general. It was clear from the students in this study that to adapt effectively to the inevitable alterations in their images, adequate support was needed. It was also clear that the system was not providing this support, and the students' images of nursing were affected accordingly. Here again, good and bad staff enter the picture. Although mechanisms of support provided by the system were lacking, individual students received effective ad hoc support from good staff, both clinical staff and teaching staff. Conversely, there were occasions on which no support was forthcoming. In some cases, this was because staff themselves were the cause of the disparity. In other cases it appeared that staff did not perceive the need for support or were incapable of providing it. Although students expressed appreciation of useful support offered by teaching staff, often there was no clinical teacher attached to a clinical area, or the assigned clinical teacher was rarely or never present ostensibly due to college commitments.

Stoller has stated that

...the greater the disparity between (student nurses') preconceptions and reality, the greater the potential for dissatisfaction in future work settings. (1978:3)

Evidence from the present study suggests a qualification to this view, namely that reasonable disparity can be unproblematic, given the right type of timely support, but lack of support can mean students have difficulty accommodating to the disparity. Gunter found in an earlier study of second-year American student nurses that "learning to accept the difference between what you expect of nursing and what nursing is really like" was the highest-ranked item among aspects of nursing that students found "not so difficult or not difficult at all" (1969:239). Their student experience occurred in a setting in which they were treated as students, not as rostered members of staff, and in which they participated in nursing care under the guidance of teaching staff. It could be argued that in such a situation, students were not yet experiencing real nursing, and that therefore the potential for disparity had not yet fully existed for them. However, it could also be contended that the presence of teaching staff whose only remit in the

clinical context relates to the teaching and support of students can facilitate effective development of a student's entry image to an inside image that is congruent with her values and ideals.

An incidental finding in relation to the conduct of the present study was that students found the research interviews useful as a form of support. This was not, of course, my intention, nor were the interviews conducted in such a way as to provide support. However, it became obvious from students' comments that the interviews served a useful purpose for them. The opportunity to express themselves freely about nursing as they were experiencing and perceiving it, and to have their ideas sought and listened to for their own sake, occurred uniquely in the research interviews. These could not be equated with counselling interviews, not only because they were not conducted in that manner, but because they were not sought or initiated by the students. If, as seemed clearly desirable from the students' accounts, a disinterested party were made available to provide counselling for student nurses, such counselling would depend on students' recognizing their need for it and seeking it out. There seems little likelihood that they would have sought me out for talks such as we had during the research interviews, because they were not at a point of perceiving themselves to have a counselling need; I just happened to come along and ask to have a talk with them. However, it does seem that the opportunity merely to express themselves and to be listened to by someone with no other agenda than to hear their ideas served a supportive purpose for the students.

Interestingly, uncanny echoes can be found between the accounts of these students and accounts cited by other researchers. In particular, resemblances can be seen to quotes from students in Melia's study of the occupational socialization of nurses (1981) and students quoted in Mackay's book *Nursing a Problem* (1989). Neither of these studies was done in the same geographical area as the present study, Melia's being carried out in a different area of Scotland and Mackay's in a mixed urban/rural context of England (1991). That is not to say that the students consistently expressed the same views, either within any of the studies or between them, but only that a degree of typicality seems to exist in the observations and comments they make.

A notable feature related to this was the quality of the interviewees' accounts. The students demonstrated a gratifying ability to express themselves, sometimes with great articulateness, sometimes colourfully, sometimes with touching poignancy, and often with refreshing spontaneity. There was much that was worth hearing in what they had to say.

Looking broadly at the students' experience-mediated images of nursing as compared with their initial images, it was clear that there continued to be diversity. One might have expected there to be more homogeneity after fourteen to eighteen months of

socialization within the same college of nursing and its affiliated clinical areas. As can be seen from the discussion in the previous chapters, neither the direction of change nor the nature of that change was uniform among the students interviewed. Lack of agreement was evident, for example, in relation to the wisdom of getting involved in students' images of the good nurse and how she should behave. Students also differed markedly in the personal orientation aspect of their images of nursing, that is, whether they saw nursing as a career choice for life or a choice for the short term.

The many other differences between students' images, and the various changes in their images, have been discussed in the previous chapters. A salient feature of the differences and changes was the impact of clinical staff at any given point in a students' experience. Students' accounts tended to be influenced by their perceptions of the staff in whichever clinical area they were working in at the time of interview.

The most abiding features of the students' images of nursing, in that they were present in most students' images, both initially and after experience, included the following:

- nursing as working with and helping people;
- nursing as more than just a job, requiring motivation and commitment, conferring a sense of belonging, and bringing about changes in the person who becomes a nurse;
- nursing as being rewarding, through knowing or seeing that you have helped, and through interpersonal relations with patients;
- nursing as entailing a drain on the nurse's personal resources; and
- typical or real nursing as adult general nursing.

This research could be expanded in a number of directions. The substantive theory base could be enlarged by carrying out a similar plan of data collection extended longitudinally to cover the full period of the students' training, and it could be continued through their period of transition to the inside vantage point of the staff nurse. This could provide an opportunity for exploring the development of their images over the longer term.

Data collection could also be undertaken with entrants to occupational fields that are analogous in the terms described by students in this study. One obvious starting point would be to explore the image of police work among police recruits. If police work indeed shares the elements attributed to it by students in the present study, and if it, too, is seen by its new members as a special world, conferring a sense of belonging to its members, this would enlarge the possibility of clarifying features of this type of status passage. Such exploration could be extended to other fields that appear to share similar attributes. These might include, for example, the fire service, the law and

medicine. There have been, of course, many studies of entry to medicine, looking at features such as the fate of idealism (Becker & Geer 1958, Schwartz *et al* 1978) and other aspects of the socialization of medical students (Merton *et al* 1957, Rogoff 1957, Becker *et al* 1961, Ewan & Bennett 1981, Wolf *et al* 1989), including the impact on personal life (Broadhead 1983). In some of these, as has been mentioned earlier, evidence relevant to occupational image exists.

One finding that should be of interest to people involved in recruiting to the nursing profession is the nearly unanimous image, which was clear at entry and persisted in the face of experience, of nursing as general nursing. Further investigation of this phenomenon might reveal its significance for the appeal of nursing as an occupational field, and its relation to the effectiveness of the types of recruiting strategies being employed.

A related feature is the persistence of the working with/helping people element as a strongly attracting component of the students' images of nursing. Research which followed students from the beginning of their training through their early experience as qualified staff might identify the impact of their need to adjust to the increasingly managerial role the students in the present study were beginning to identify as an inevitable (and largely undesirable) part of their own future roles.

Although the analysis in the present research was necessarily confined to the focus of the study, that is, to the students' images of nursing, the data suggested other lines of inquiry which would be worth investigating. For example, the evidence of the students' personal development over the period of the study suggests the value of exploring this feature of student nurses' experience in relation to Perry's model (1970) of the intellectual and ethical development of university students.

In practical terms, three particular issues highlighted by the students' accounts appear to warrant further investigation. One of these is the good staff/bad staff issue. This is not a new topic for research, of course, but it is noticeable that findings in this regard seem to have changed little over the years. Studies carried out many years ago as well as recent studies, in the context of different types of training programmes, repeatedly reveal many of the same features. Perhaps what is needed is research that goes beyond identifying the characteristics of good and bad staff and explores why staff are as they are, whether good or bad.

A second issue is the students' need for support mechanisms to be provided by the system. It seems apparent that the ad hoc basis by which students in the present study were offered support, and which can be assumed to operate in other contexts as well, is not adequate to meet their needs. This clearly has implications for policy and practice as well as for research.

Thirdly, the present evidence suggests the need for rethinking the assumptions that underpin the policy by which student nurses are repeatedly required to readjust to

different placements, spending relatively short periods of time in each. In Scotland, most modular schemes of training that were instituted when the 1982 syllabus was implemented entailed clinical allocations that were longer than had been the case in the schemes which they replaced. Thus it might have been hoped that the problems identified by Melia in her research (1981), particularly in relation to their fostering of a sense of transiency, would have been ameliorated. However, from the present study, and from evidence found by Findlay (1991) and by Forsyth (study in progress [1992]), it would seem that the problems associated with the repeated need to settle in to practice placements are far from remedied.

These three issues are obviously interrelated. Long placements in clinical areas with bad staff within a system which offered inadequate supportive mechanisms would obviously not constitute an improvement over the present situation. Conversely, short placements with a clear educational focus and well-supported by education staff, as might be instituted in Project 2000 diploma programmes, might not be a problem for students. Thus attention to one of these issues without regard for the other two could be wasteful or damaging. However, exploration of the three in conjunction with one another would seem to be vital to students' learning and well-being, and thus to the future health of the profession. The interpretation of findings in the present study has suggested that students may be well able to handle disparity between their necessarily naïve and generally idealistic entry images and the perceived reality of their experience within the world of nursing, given a supportive context within which their experience-mediated images may develop.

APPENDICES

RESEARCH QUESTIONNAIRE

Appendix 1

Personal information given in answer to questions will be held strictly confidential by the researcher and will only ever be used anonymously.

Name _____ Age _____

Entry date _____ Sex (please circle): M F

Type of training (please circle): RGN RMN RNMH RSCN

Home town or area _____

Country of birth _____ Nationality _____

Any work experience related to nursing (state type and length of time):

Any other work experience: _____

School subjects (please list, indicate qualification attempted and grade achieved): _____

Any other educational qualifications/experiences: _____

(Questionnaire continues overleaf)

Is anyone in your family (or has anyone in your family been) a nurse?

If so, who, and in what capacity? (e.g. father a registered nurse,

sister a student nurse, aunt a nursing auxiliary) _____

Is anyone in your family in another health or health-related profession?

If so, who, and in what profession? _____

Please write out your answers to the following:

Appendix 2

1) Describe your idea of "nursing."

2) Describe your idea of "a good nurse."

(Please continue overleaf.)

2) (continued)

3) Where do you believe you got your ideas or information about nursing?
(If you mention TV programmes, books, libraries, or information from colleges, please be as specific as you can, e.g. by giving titles of books or names of colleges.)

4) Thank you for helping me with my research study. I will be needing further ideas from some members of your group in the near future. Would you be willing to participate in an informal personal interview?

Yes _____ No _____ (A "yes" answer is not binding.)

**IMAGES OF NURSING AMONG NEW STUDENT NURSES:
THE GOOD AND THE BAD**

Alice M.Kiger

Department of Education
University of Aberdeen
Scotland, U.K.

From the published proceedings of:
**5th Biennial Conference of the
Workgroup of European Nurse Researchers
September 5 - 7, 1990
Budapest, Hungary**

IMAGES OF NURSING AMONG NEW STUDENT NURSES: THE GOOD AND THE BAD

Alice M. Kiger
Education Department, University of Aberdeen, Scotland, U.K.

The conceptual themes discussed in this paper emerged during a qualitative study of the "image of nursing" as elicited in oral accounts of student nurses who had recently entered training. The design of the study was based on the "grounded theory" approach described by Glaser and Strauss (1967).

Design of the Study

The selection of the first few research subjects was made purposively from a convenient population of students, and was based on information from a set of questionnaires administered at the commencement of their training. The technique of theoretical sampling was used to select further subjects from the same population (Strauss 1970). In all, the sample comprised 24 student nurses (21 female and 3 male) from 3 consecutive intakes of students to basic training in a single Scottish nursing college. They constituted approximately 16.6% of the total number of students in the 3 intake groups.

Informal unstructured interviews were conducted, each student being interviewed individually on 3 occasions: (1) during the first 5 weeks of training, before any clinical experience as a student; (2) during the 6th-8th month of training, after experience in 2 clinical areas; and (3) during the 12th-18th month of training, after experience in at least 4 clinical areas. The technique of constant comparative analysis was employed concurrently with the collection of the interview data (Fagerhaugh & Strauss 1977).

For the purpose of the study, "image of nursing" was taken to mean the students' complex mental representations of the concept "nursing", in whatever sensory modalities it existed for each of them. The aim of the interviews was to elicit the students' introspective accounts of those representations. (See e.g. Morris & Hampson 1983.)

Entry images

From the analysis of the data from the first round of interviews, 5 broad themes emerged:

- (1) "pictures of nursing" - drawn from the visual images of nursing the students described;
- (2) "the (good) nurse" - drawn from the students' descriptions of "what a nurse is like" (often emerging as "what a **good** nurse is like");
- (3) "about me and nursing" - drawn from elements of their accounts reflecting their own relationships to the image;
- (4) "what nursing entails" - drawn from their ideas of what nurses do and what the experience of nursing is like for nurses; and
- (5) "what nursing is" - drawn from their explanations of the occupational labels they thought appropriate for nursing.

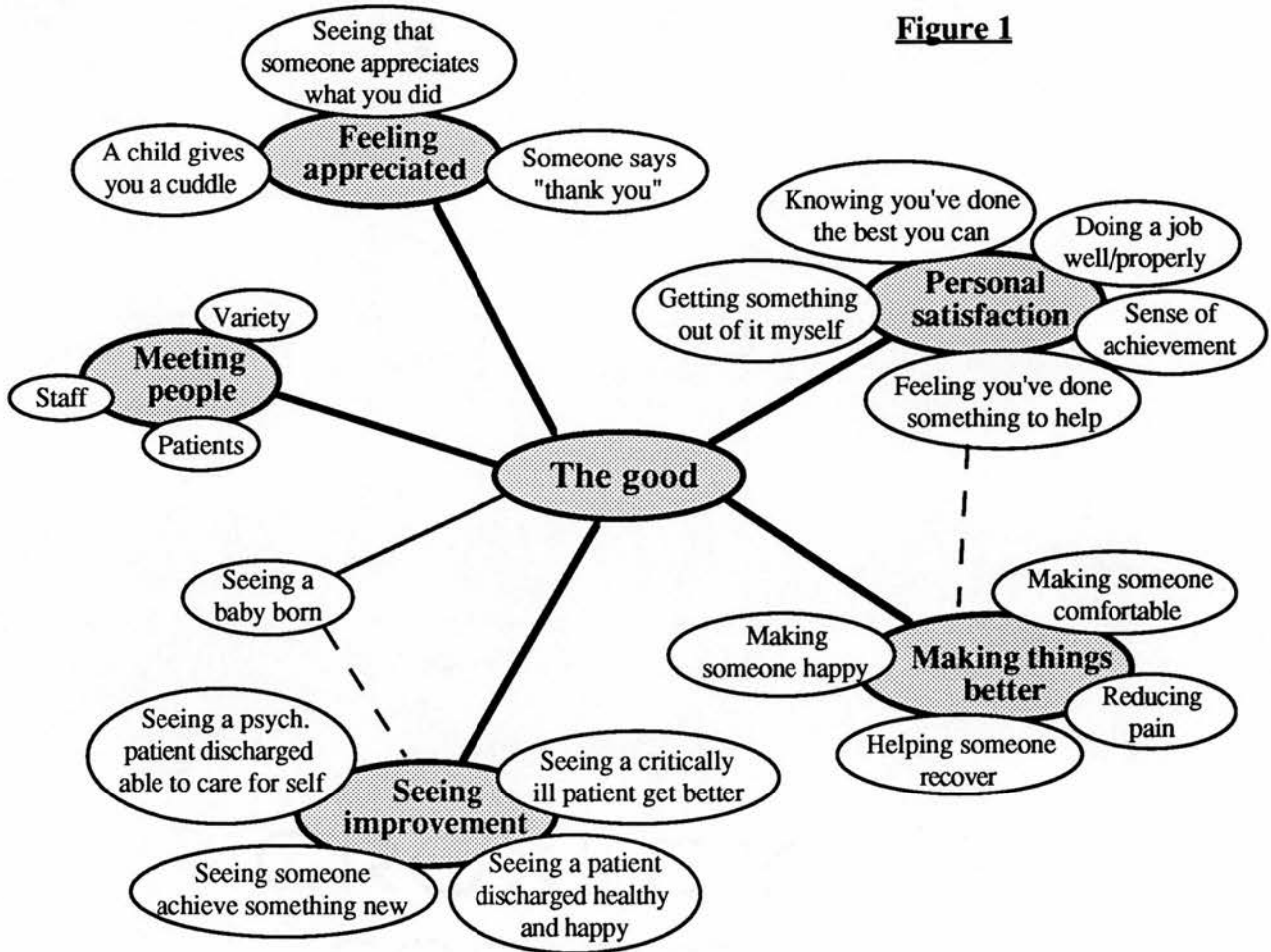
The sub-themes "the good" and "the bad" were a part of (4) above.

"The good"

"The good" was the label assigned to the group of elements which students described as being the rewards or satisfactions that nursing would bring. It is useful to point out here that as the interviews progressed, it became clear that confining the discussion specifically to "image", as distinct from "expectations", was a virtual impossibility. The students inevitably wanted to put

themselves into the pictures they were describing, and thus their "images" were personalized. This is not surprising, given that the concept under discussion was the occupational field they were in the process of entering, and given that "images are not merely imitations, but memory fragments, reconstructions, reinterpretations, and symbols that stand for objects, feelings or ideas" (Horowitz 1978). Thus the images being described had been formed by the individual students about something that was currently of direct relevance to their experience and interest.

The component elements of "the good" can be seen in Figure 1. It will be noted that the specific examples are not all grammatically consistent within the various elements, nor are the elements themselves grammatical equivalents. This is because, whenever possible, they are stated in terms the students themselves used, though they are arranged according to the researcher's interpretation of their relationships to the conceptual themes that were seen to emerge.



One of the interesting features of "the good" is that some of its elements were passive factors while others were active ones. "Seeing improvement", for example, was an element of passive experience.

Lorna¹ - "... when you see somebody walking out the door that's fitter than when they came in."

Carol - "... seein' a patient leavin' would be very rewardin', kennin' that they're goin' home to their family."²

It seemed that these students, and others who offered similar comments, imagined the nurse's receiving satisfaction merely from seeing good things happen to other people. "Making things

better", on the other hand, contained a notion of the nurse's satisfaction from having had a hand in causing the good things to happen. The good things, in this case, might involve recovery or comfort.

Ian - "Bein' able to help someone, just bein' able to help people, make people better."

Angela - "I think if you have a terminally ill patient that comes in in great pain and you can keep them comfortable . . . I think that would give you a sense of satisfaction to know that you've actually helped to relieve their pain."

There was another contrast between the outward evidence of gratitude that the students believed nursing would entail, and the inner sense of satisfaction they imagined the nurse to feel, independent of tangible evidence.

Donna - ". . . somebody come up and give you a cuddle . . . if a kiddie comes up to you and sorta, before they leave the ward, come up to you and say 'thank you', that's really nice. That, that would be nice."

Joanne - ". . . knowing you've done a worthwhile job."

Natalie - "I don't think you should expect, you know, to be trumpets blowing or anything particularly like that. I think you just feel it, you know, within yourself, really."

And finally among the elements of "the good", the students believed there was satisfaction to be gained just from working with people and building relationships.

Kathy - ". . . meeting so many different types of folk in the wards, and patients and the staff . . . you'd make different relationships on different levels, but you're always learning something about people and about yourself."

Wendy - "Hopefully, workin' with nice staff. People goin' in to meet other folk that, you know, enjoy their work as well . . . everybody's happy [laughs]."

"The bad"

On the other side of the conceptual coin was "the bad". This consisted of those features the students imagined to be unpleasant in nursing, or situations that were difficult for the nurse to cope with. The elements of "the bad" are represented in Figure 2.

"Death", "suffering" and "giving bad news" as a constellation of related elements loomed large in the students' accounts.

Donna - "I think the most difficult would have to be dying, somebody dying, especially if you get to know them, I think this must be really really difficult, in fact I'm really dreading it happening, I'm really dreading it. Cause I've never experienced it before, you know, so I'm just thinking, ooh, I hope I don't come across it too soon. That must be the worst thing. And maybe trying to help the mums or the relatives through it."

Rachel - ". . . it would be terrible if somebody died and they were terrified. You would try to reassure them . . . If I thought they'd died at peace I would be, OK I'd probably be upset, but I would feel, oh well, that's better. If they died in an awful lot of pain and anguish and that, then you'd think, oh, I wish I'd been able to do somethin' more for them."

Kathy - ". . . how to tell relatives someone's died, or having to tell the patient, or if he asks you a straight quesiton, how do you answer him . . ."

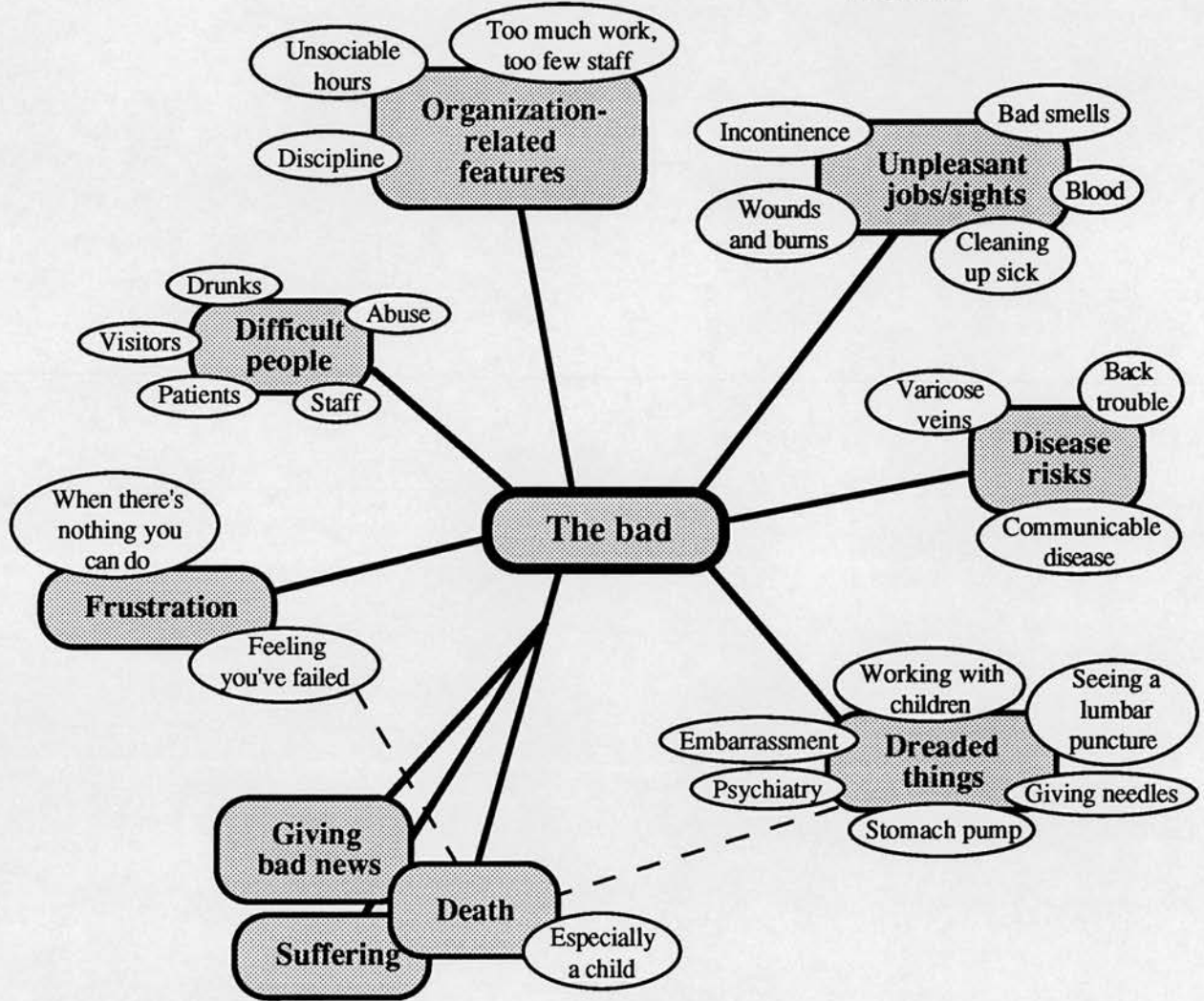
The link between this trio of elements and "frustration" is exemplified by Rachel's account above, and its link with "dreaded things" is well illustrated in Donna's. Other dreads included:

Lorna - "I'm dreading my first bed bath to a man!"

Carol - "Givin' people needles! I'm dreadin' that!"

Some students had dreads related to specific clinical areas of nursing that they thought they were going to find difficult or unpleasant.

Figure 2



In comparison with the high profile of the above mentioned elements of "the bad", other elements were trivial in terms of the weight given them by the students in their initial interviews. "Disease risks" were suggested laughingly; "unpleasant jobs/sights" were offered as ideas of features that might put other people off nursing, but did not matter to the interviewees; and "difficult people" were just mentioned as incidental possibilities. The "organization-related features" were factors they seemed aware of due to publicity, and those who mentioned them seemed to think that the system could be better organized to minimize them, but also seemed to believe that individuals who were suited to nursing could tolerate them without too much difficulty.

Images into experience

The evolution of "the good" and "the bad" was clear in the students' accounts during their second and third interviews. Some features of their original images remained, either because they had

been reinforced by the students' experiences of reality, or because the opportunity to experience them had not yet been encountered and so they remained as untested images. Other features disappeared, altered, or appeared for the first time.

In general form, "the good" remained intact, but its elements were further defined and filled out. Even more than in the first interviews, the students put themselves into their pictures, and it was clear that experience had been operating on the construction of their images. An extract from Lorna's interview illustrates this:

AK - "What would you say now are the satisfactions in nursing?"

Lorna - ". . . at the children's hospital, I could see them goin' out well and happy, and here [mental handicap hospital], just seein' them laughin', you know, just bein' happy, and comin' over to you and you get cuddles and bozies [hugs]."

Seeing improvement, getting thanks, feeling a sense of achievement and working with people continued to be recurring features of "the good".

Gail - "It's nice if people say thank-you for things . . . you feel as though you've achieved something."

Sarah - ". . . (when patients tell you their problems) then they feel a lot better . . . And that makes you feel really good, cause you think, oh well, you know, I've made them feel a lot better . . . I think that makes the job really good."

Further refinements of these elements appeared, such as "feeling needed" and "being valued". There also emerged a clear new element that overlay much of the content of "the good", and that element revolved around the clinical staff. This will be discussed below, along with its complementary opposite in "the bad".

In its general form, "the bad" seemed to alter more than "the good". A number of features were retained, again either because they fitted with experience or because they had not yet been encountered. For example, "mucky jobs" indeed existed for the students, while a patient's death had not yet occurred for some who had dreaded it. One "organization-related" element that was strengthened was the "overworked and understaffed" aspect. It assumed greater importance in the students' views because when they found themselves in such a situation, they were frustrated and dissatisfied with the standard of care they were able to provide.

Malcolm - ". . . one of the most frustratin' things was when you had to rush things. When you didn't really do things to the best that you could . . . That gets to you."

The major changes in "the bad" consisted of unanticipated features of nursing, or more specifically, of **student** nursing. One element that often appeared was the pressure entailed in the dual student/worker role.

Valerie - ". . . the last thing you want to do when you come home at night is to sit and study. I mean, your days off, you're too busy just sorta catchin' up on sleep and washin' and ironin' . . ."

Related to this were students' descriptions of the lack of facilities for their own support. They felt that they were expected to be students, but that there were not the mechanisms they expected in an educational system to meet their academic, psychological, social and emotional needs.

Eileen - ". . . you find that nobody cares about nurses . . . we don't have . . . I don't know, we should have a lot more discussion sessions and yoga classes or whatever, you know, we should have a lot more care taken, it's a caring profession, but they don't care about their [student] nurses."

An outstanding feature of "the bad" that was revealed by the students' accounts at this stage was, as has been mentioned above in relation to "the good", the clear impact of clinical staff.

"The staff make or break the ward for you"

"Staff" as an element of a conceptual scheme seemed to stand on a bridge between the sub-themes "the good" and "the bad", with two very different faces looking opposite ways. Staff behaviours and attitudes presented by one face resulted in students' feelings and responses that constituted part of "the good" as it appeared in their experience-mediated images of nursing. That is --

If staff: introduce themselves, act friendly, use first names, teach and explain things, give feedback, give guidance but allow use of initiative, "muck in" with the work, treat students as adults, keep students informed about what's going on in the ward, and give support when it's needed . .

. . then students: feel welcome, feel relaxed, gain satisfaction from learning, know how they're progressing, gain confidence, feel like members of the team, feel respected, feel valued, and can gain positive value from even difficult experiences.

Staff behaviours and attitudes belonging to the other face led to students' feelings and responses which constituted a major component of "the bad" in their experience-mediated images. That is --

If staff: act unfriendly, don't introduce themselves, don't speak to students, act stiff and formal, stay in the office doing paper work, don't share in the care of patients or in the dirty jobs, treat students "like rubbish", don't teach or explain things, don't give students a chance to see new things, don't tell the students what's going on, don't give feedback, don't show that they care about students' needs, and are not enthusiastic . .

. . then students: feel unwelcome, feel like "just pairs of hands", feel like "skivvies", feel unappreciated, feel left out, don't feel they are learning, feel insecure, don't know what they should be doing, lose self-esteem, don't respect staff, and don't enjoy nursing.

Extracts from the students' accounts illustrate the contrast between the effects of the two "faces":

Joanne - "(The staff) were so nice . . the first day I got there they just introduced me to everybody . . (after an upsetting death) they took me to the room for a coffee and everything, and it was really nice . . so friendly, I could speak to them about anything, if I had any problems."

Carol - "It was just fantastic . . the staff were really nice and you learnt so much . . there was always somebody there to ask if you got stuck . ."

Yvonne - "It was like everybody was on the same level . . we just did equal work . . there was nane o' this somebody sittin' in an office an leavin' us to do everything. It was brilliant, a'boday [everybody] just mucked in."

and:

Lorna - "They just left us in the ward by ourselves . . You never got any praise for what you did do right . . they wouldn't speak to you . . it took them ages to learn my name . . you couldn't really tell if you were doin' your job properly."

Donna - "I expected the staff to be all for gettin' the students trained, but when you get there you're treated like dirt."

Ian - ". . you seem to be so often by yourself with another student, and you're never quite sure what to do . . when you're unsure and you're by yourself, it's so easy to imagine that you're not doin' well or it's so easy to feel a fool or as if you've done something wrong."

The implications of these comments were neatly summarized by Wendy:

"The staff make or break a ward for you, and if you get good staff, fair enough, but if you don't . . . !"

Transformations

For some students, the move into the "inside" of nursing seemed to bring about interesting transformations. A fairly simple example of this was the dread of giving injections. Often, after giving a few injections, a student lost that dread, and in some cases did not even recall, until reminded, that the dread had ever existed. Thus it might disappear from "the bad" altogether.

A more complex transformation involved the students' experiences with dying and death. Dealing with death had initially featured strongly in their ideas of "the bad". However, in second and third interviews, hints began to emerge that there were ways in which death-related experiences were moving into "the good". Students found they gained satisfaction from feeling needed, feeling they had done a worthwhile job, feeling they had made someone's last hours more comfortable or peaceful, getting thanks, and so on. In addition, such feelings seemed to take on a certain poignancy because of the circumstances.

One of the best examples of this transformation was offered by Carol in her second interview. During her description of a particularly harrowing day on a medical ward, she gave this account of an experience with one of the very ill patients:

Carol - ". . . he was just a wee tiny man, he just lay in this big bed and he looked so small, and he was really really skinny, aw, there was just nothin' o' him . . . and he was so weak he couldna hold his cup or anything, so I was holdin' his cup, I give him a straw and he was drinkin' his milk, and his son came in, and I suppose it must have been a shock to his son seein' him in this big bed lookin' so ill, and he started cryin', but he was tryin' not to let his father see that he was cryin', and I was givin' this wee mannie his drink of milk, and he says "Thank you, nurse," and he gave me a big kiss, and I went through the back and I cried. . . And the only care we could give him was lovin' care . . . and I went off on my days off, and I thought, "When I come back, is he still gonna be there?" He was there, but he died that day when I came back. But that was really, I was the first person he'd spoken to in two months, oh it was really, god it was, oooh! But that's what it's all about."

AK - ". . . was that a rewarding experience for you?"

Carol - "Yes, it was, aye, it was really, oh, the air was full of, just electric, it was -- oh, I don't know, it's hard to describe, well, it just makes you think, 'Well, this is what I'm here for.'"

This seems to imply that one of the most difficult and emotionally draining aspects of a nurse's experience can also be among the most rewarding, and that this is perhaps the essence of nursing. Thus this particular "bad" element could be transformed into a signally "good" one.

Final note

This is not a conclusion, for the analysis of the data gathered for this study is still in progress. It is clear, however that insights are emerging which have affinities with the work of many other researchers and writers, ranging from Becker and Geer, who investigated "The Fate of Idealism in Medical School" in the 1950s, through Melia's exploration of student nurses' experiences of "Learning and Working" in the past decade (1981, 1987). Works by the Oxford Area Nurse Training Committee (1966), MacGuire (1969), Brown and Fowler (1971), Birch (1975), Simpson (1979), Davitz and Davitz (1980), Lavandero (1981), Heyman et al (1983), Reid (1985), and Raeburn (1990), are all relevant.

One broad implication that is evident from these students' accounts is that many of the factors that either facilitate or inhibit the development of a student nurse's potential, and that make the student's experience either rewarding or disappointing, do not exist by chance. In many critical instances, it is the qualified clinical staff who "make or break" the student's experience.

FOOTNOTES

1 Names of students are fictitious.

2 Many of the students spoke in local Scottish dialect, which is not a written language. "Hame", for example, is the local word for "home", and "kennin'" means "knowing" (final 'g' often not pronounced). Number and tense are sometimes inconsistent with ordinary grammatical rules. The flavour of this dialect has been retained as much as possible. When a meaning is not obvious, a translation is provided in brackets.

REFERENCES

- Becker H S & Geer B (1958) The Fate of Idealism in Medical School. *American Sociological Review* 23(1): 50-56.
- Birch J A (1975) *To Nurse or Not to Nurse: An Investigation into the Causes of Withdrawal During Nurse Training*. London: Royal College of Nursing.
- Brown M M & Fowler G F (1971) *Psychodynamic Nursing: A Biosocial Orientation*, 4th Edition. Philadelphia: W B Saunders Company.
- Davitz L L & Davitz J R (1980) *Nurses' Responses to Patients' Suffering*. New York: Springer Publishing Company.
- Fagerhaugh S Y & Strauss A (1977) *Politics of Pain Management: Staff-Patient Interaction*. Menlo Park, California: Addison-Wesley Publishing Company, Health Sciences Division.
- Glaser B G & Strauss A L (1967) *The Discovery of Grounded Theory: Strategies for Qualitative Research*. Chicago: Aldine.
- Heyman R, Shaw M P & Harding J (1983) A personal construct theory approach to the socialization of nursing trainees in two British general hospitals. *Journal of Advanced Nursing* 8(1): 59-67.
- Horowitz M J (1978) *Image Formation and Cognition*, 2nd Edition. New York: Appleton-Century-Crofts.
- Lavandero R (1981) Burnout Phenomenon: A Descriptive Study Among Nurses. *American Journal of Nursing* 81(2): 356.
- MacGuire J (1969) *Threshold to Nursing*. Occasional Papers on Social Administration No 30. London: G Bell & Sons Ltd.
- Melia K (1987) *Learning and Working: The Occupational Socialization of Nurses*. London: Tavistock Publications.
- Melia K M (1981) "Student Nurses' Accounts of their Work and Training: A Qualitative Analysis." Unpublished PhD thesis, University of Edinburgh.
- Morris P E & Hampson P J (1983) *Imagery and Consciousness*. London: Academic Press.
- Oxford Area Nurse Training Committee (May 1966) *From Student to Nurse: Training and qualification -- A study of student nurses in training at five schools of nursing*. Oxford: Area Nurse Training Committee.
- Raeburn M F (1990) "The Male Student -- Factors Affecting his Entry into Nurse Education: A Qualitative Study." Unpublished MEd thesis, University of Aberdeen, Scotland.
- Reid N G (1985) The effective training of nurses: manpower implications. *International Journal of Nursing Studies* 22(2): 89-98.
- Simpson I H (1979) *From student to nurse: A longitudinal study of socialization*. Cambridge: Cambridge University Press.
- Strauss A (1970) Discovering New Theory from Previous Theory. In T Shubutani, ed. *Human Nature and Collective Behaviour -- Papers in Honor of Herbert Blumer*. Englewood Cliffs, N J: Prentice-Hall, Inc. Pp 46-53.

REFERENCES

REFERENCES

- Alexander D A & Ritchie E (1989) Attitudes to death, 'stressors' in palliative care and nurses' reactions to them. Unpublished research report, Medical School, University of Aberdeen.
- Alexander M F (1983) *Learning to Nurse — Integrating Theory and Practice*. Edinburgh: Churchill Livingstone.
- Antle May K (1980) A Typology of Detachment/Involvement Styles Adopted During Pregnancy By First-Time Expectant Fathers. *Western Journal of Nursing Research* 2(2): 444-453.
- Antle May K (1991) Interview Techniques in Qualitative Research: Concerns and Challenges. In: J M Morse (ed), *Qualitative Nursing Research: A Contemporary Dialogue*, Revised Edition. Newbury Park, California: Sage Publications. Pages 188-201.
- Artinian B M (1982) Conceptual Mapping: Development of the Strategy. *Western Journal of Nursing Research* 4(4): 379-393.
- Atwood J R (1977) A Grounded Theory Approach to the Study of Perimortality Care. In: M V Batey (ed), *Communicating Nursing Research. Volume 9: Nursing Research in the Bicentennial Year*. Boulder, Colorado: Western Interstate Commission for Higher Education. Pages 339-350.
- Becker H S (1970a) Interviewing Medical Students. In: W J Filstead (ed), *Qualitative Methodology: Firsthand Involvement with the Social World*. Chicago: Markham Publishing Company.
- Becker H S (1970b) *Sociological Work: Method and Substance*. New Brunswick, N.J.: Transaction Books.
- Becker H S & Carper J (1970a) The Development of Identification with an Occupation. In: H S Becker, *Sociological Work: Method and Substance*. New Brunswick, N.J.: Transaction Books. Pages 189-201.
- Becker H S & Carper J (1970b) The Elements of Identification with an Occupation. In: H S Becker, *Sociological Work: Method and Substance*. New Brunswick, N.J.: Transaction Books. Pages 177-188.
- Becker H S & Geer B (1957) Participant Observation and Interviewing: A Comparison. *Human Organization* 16(3): 28-32.
- Becker H S & Geer B (1958a) "Participant Observation and Interviewing": A Rejoinder. *Human Organization* 17(2): 39-40.
- Becker H S & Geer B (1958b) The Fate of Idealism in Medical School. *American Sociological Review* 23(1): 50-56.
- Becker H S, Geer B, Hughes E C & Strauss A L (1961) *Boys in White — Student Culture in Medical School*. Chicago: The University of Chicago Press.
- Benoit C (1989) The professional socialization of midwives: Balancing art and science. *Sociology of Health & Illness* 11(2): 160-180.

Benoliel J Q (1977) Conceptual Precision and Research about Human Dying. In: M V Batey (ed), *Communicating Nursing Research. Volume 9: Nursing Research in the Bicentennial Year*. Boulder, Colorado: Western Interstate Commission for Higher Education. Pages 237-243.

Birch J A (1975) *To Nurse or Not to Nurse: An Investigation into the Causes of Withdrawal During Nurse Training*. London: RCN.

Birch J (1979) The Anxious Learners. *Nursing Mirror* 148(6): 17-22.

Blumer H (1962) Society as Symbolic Interaction. In: A Rose (ed), *Human Behavior and Social Processes*. Boston: Houghton-Mifflin. Pages 179-192.

Blumer H (1969) *Symbolic Interactionism — Perspective and Method*. Englewood Cliffs, New Jersey: Prentice-Hall, Inc.

Boehm K & Lees-Spalding J, eds (1991) *The Student Book 1992*. London: Macmillan.

Bogdan R & Taylor S J (1975) *Introduction to Qualitative Research Methods: A Phenomenological Approach to the Social Sciences*. New York: John Wiley & Sons.

Boulding K E (1956) *The Image*. Ann Arbor: The University of Michigan Press.

Boylston H D (1939) *Sue Barton – Student Nurse*. Sevenoaks, Kent: Knight Books.

Boylston H D (1940) *Sue Barton – Senior Nurse*. Sevenoaks, Kent: Knight Books.

Boylston H D [1940] (P/b 1967, 14th impression 1984) *Sue Barton – Senior Nurse*. London: Knight Books.

Boylston H D [1941] (P/b 1967, 10th impression 1982) *Sue Barton – Visiting Nurse*. London: Knight Books.

Boylston H D [1942] (P/b 1967, 11th impression 1981) *Sue Barton – Rural Nurse*. London: Knight Books.

Brand C (1964) *Nurse Matilda*. Great Britain: Knight Books.

Brink P J (1991) Issues of Reliability and Validity. In: J M Morse (ed), *Qualitative Nursing Research, A Contemporary Dialogue*, Revised Edition. Newbury Park, California: Sage Publications. Pages 164-186.

Broadhead R S (1983) *The Private Lives and Professional Identity of Medical Students*. New Brunswick [NJ]: Transaction Books.

Bucher R & Strauss A (1961) Professions in Process. *American Journal of Sociology* 66(4): 325-334.

Burgess R, ed (1985a) *Field Methods in the Study of Education*. London: The Falmer Press.

Burgess R G, ed (1985b) *Strategies of Educational Research: Qualitative Methods* (Social Research and Educational Studies Series: 1). London: The Falmer Press.

Burnstein E, Moulton R & Liberty P (1963) Prestige vs. Excellence as Determinants of Role Attractiveness. *American Sociological Review* 28(2): 212-219.

- Bush M A & Kjervik D K (1979) The nurse's self-image. In: D K Kjervik & I M Martinson (eds), *Women in Stress: A Nursing Perspective*. New York: Appleton-Century-Crofts. Pages 46-58.
- Butler D (1990) *In Hospital*. London: Simon & Schuster.
- Careers & Occupational Information Centre 91989) *Working in Nursing (Working in Series No. 20)*. Sheffield: COIC.
- Chapman C M (1977) Image of the Nurse. *International Nursing Review* 24(6): 166-167, 170.
- Chaska N L, ed (1978) *The Nursing Profession: Views through the Mist*. New York: McGraw-Hill Book Company.
- Chenitz W C (1986) The Informal Interview. In: W C Chenitz & J M Swanson (eds), *From Practice to Grounded Theory — qualitative research in nursing*. Menlo Park, California: Addison-Wesley Publishing Company. Pages 79-90.
- Chenitz W C & Swanson J M (1986) *From Practice to Grounded Theory — qualitative research in nursing*. Menlo Park, California: Addison-Wesley Publishing Company.
- Clark R (1989) *Careers in Nursing and Allied Professions*, 4th Edition. London: Kogan Page.
- Clark R & Moss S (1985) *Careers in Nursing and Allied Professions*, 3rd Edition. London: Kogan Page.
- Clarke M (1978) Getting through the work. In: R Dingwall & J M McIntosh (eds), *Readings in the Sociology of Nursing*. Edinburgh: Churchill Livingstone. Pages 67-86.
- Cohen L & Manion L (1985) *Research Methods in Education*, 2nd Edition. London: Croom Helm.
- Coler M S & Sutherland M (1983) A semiquantitative method to assess role image in nursing through the application of semantics. *International Journal of Nursing Studies* 20(4): 223-230.
- Cordiner C (1968) Personality Testing of Aberdeen Student Nurses. *Nursing Times* 64(6): 178-180.
- Corwin R G (1961) Role Conception and Career Aspiration: A Study of Identity in Nursing. *Sociological Quarterly* 2: 69-86.
- Cross K W & Hall D L A (1954) Survey of Entrants to Nurse Training Schools in the Birmingham Region. *British Journal of Preventive and Social Medicine* 8: 70-76.
- Cruickshank J M (1991) A Qualitative Study: First Module Student Nurses' Feelings and Perceptions towards their Care of the Elderly and Elderly Mentally Ill Experience. Unpublished MEd thesis, University of Aberdeen.
- Davis F, ed (1966) *The Nursing Profession: Five Sociological Essays*. New York: John Wiley & Sons, Inc.

- Davitz L J & Davitz J R (1975) How Do Nurses Feel When Patients Suffer? *American Journal of Nursing* 75(9): 1505-1510.
- Davitz L J & Davitz J R (1980) *Nurses' Responses to Patients' Suffering*. New York: Springer Publishing Company.
- De Fleur M L (1964) Occupational Roles as Portrayed on Television. *Public Opinion Quarterly* 28(1): 57-74.
- Denzin N K (1970) *Sociological Methods: A Sourcebook*. Chicago: Aldine Publishing Company.
- Denzin N K (1978) *The Research Act: A Theoretical Introduction to Sociological Methods*, 2nd Edition. New York: McGraw-Hill Book Company.
- Department of Health and Social Security and the Central Office of Information (1983) *Nursing*. N.p.: HMSO.
- Devereux G & Weiner F R (1950) The Occupational Status of Nurses. *American Sociological Review* 15: 628-634.
- Dingwall R W J & McIntosh J (1978) *Readings in the Sociology of Nursing*. Edinburgh: Churchill Livingstone.
- Dingwall R & Murray T (1983) Categorisation in accident departments: 'good' patients, 'bad' patients and 'children'. *Sociology of Health and Illness* 5(2): 127-148.
- Doob L W (1972) The Ubiquitous Appearance of Images. In: P W Sheehan (ed), *The Function and Nature of Imagery*. New York: Academic Press. Pages 311-332.
- Duffy M E (1985) Designing nursing research: the qualitative-quantitative debate. *Journal of Advanced Nursing* 10: 225-232.
- Dunkelberger J E & Aadland S C (1984) Expectations and Attainment of Nursing Careers. *Nursing Research* 33(4): 235-240.
- Ewan C E & Bennet M J (1981) Medicine in prospect — the first-year students' view. *Medical Education* 15: 287-293.
- Fagerhaugh S Y (1974) Pain Expression and Control on a Burn Care Unit. *Nursing Outlook* 22(10): 645-650.
- Fagerhaugh S Y & Strauss A (1977) *Politics of Pain Management: Staff-Patient Interaction*. Menlo Park, California: Addison-Wesley Publishing Company, Health Sciences Division.
- Field P A & Morse J M (1985) *Nursing Research: The Application of Qualitative Approaches*. London: Croom Helm.
- Filstead W J, ed (1970) *Qualitative Methodology: Firsthand Involvement with the Social World*. Chicago: Markham Publishing Company.
- Findlay H (1991) Settling In: An Unsettling Experience for Student Nurses. Unpublished MEd thesis, University of Aberdeen.
- Ford T R & Stephenson D D (1954) *Institutional Nurses: Roles, Relationships and Attitudes in Three Alabama Hospitals*. A Study Conducted by the Committee on

Human Relations of the University of Alabama for the Alabama State Nurses Association under Sponsorship of the American Nurses' Association. University, Alabama: University of Alabama Press.

Forsyth F [1992] Research in progress, University of Aberdeen Department of Education.

Fretwell J E (1982) *Ward Teaching and Learning — Sister and the Learning Environment*. London: Royal College of Nursing.

Gaze H (1991) Changing images. *Nursing Times* 87(20): 16-17

Georgeson V (1979) *Angels — Duty Calls*. London: Severn House.

Gibson E & Olum V (1960) Experimental methods of studying perception. In: P H Mussen (ed), *Handbook of Research Methods in Child Development*. New York: Wiley. Pages 311-373.

Glaser B G (1965) The Constant Comparative Method of Qualitative Analysis. *Social Problems* 12(5): 436-445.

Glaser B G (1966a) Disclosure of Terminal Illness. *Journal of Health and Human Behavior* 7: 83-91.

Glaser B G (1966b) The Social Loss of Aged Dying Patients. *Gerontologist* 6: 77-80.

Glaser B G (1978) *Theoretical Sensitivity: Advances in the Methodology of Grounded Theory*. Mill Valley, California: The Sociology Press.

Glaser B G & Strauss A L (1964a) Awareness Contexts and Social Interaction. *American Sociological Review* 29: 669-679.

Glaser B G & Strauss A L (1964b) The Social Loss of Dying Patients. *American Journal of Nursing* 64: 119-121.

Glaser B G & Strauss A L (1965a) *Awareness of Dying*. Chicago: Aldine.

Glaser B G & Strauss A L (1965b) Temporal Aspects of Dying as a Non-scheduled Status Passage. *American Journal of Sociology* 71: 48-59.

Glaser B G & Strauss A L (1967) *The Discovery of Grounded Theory: Strategies for Qualitative Research*. Chicago: Aldine.

Glaser B G & Strauss A L (1968) *Time for Dying*. Chicago: Aldine.

Glaser B G & Strauss A L (1970) Discovery of Substantive Theory: A Basic Strategy Underlying Qualitative Research. In: W J Filstead (ed), *Qualitative Methodology: Firsthand Involvement with the Social World*. Chicago: Markham Publishing Company. Pages 288-304.

Glaser B G & Strauss A L (1971) *Status Passage*. Chicago: Aldine.

Glaser D (1980) The interplay of theory, issues, policy and data. In: M W Klein & K S Teilmann (eds), *Handbook of Criminal Justice*. Beverly Hills, California: Sage Publications. Pages 123-142.

- Glaser W B (1966) Nursing Leadership and Policy: Some Cross-National Comparisons. In: F Davis (ed), *The Nursing Profession: Five Sociological Essays*. New York: John Wiley & Sons, Inc. Pages 1-59.
- Gordon R (1972) A Very Private World. In: P W Sheehan (ed), *The Function and Nature of Imagery*. New York: Academic Press. Pages 63-90.
- Gott M (1984) *Learning Nursing — A study of the effectiveness and relevance of teaching provided during student nurse introductory course*. London: Royal College of Nursing.
- Gunter L M (1969a) The Developing Nursing Student. Part I. A Study of Self-Actualizing Values. *Nursing Research* 18(1): 60-64.
- Gunter L M (1969b) The Developing Nursing Student. Part II. Attitudes Toward Nursing as a Career. *Nursing Research* 18(2): 131-136.
- Gunter L M (1969c) The Developing Nursing Student. Part III. A Study of Self-appraisals and Concerns Reported during the Sophomore Year. *Nursing Research* 18(3): 237-243.
- Haas E, Taves M & Shaw D (1961) Primary Group Influence on Vocational Choice. *Sociological Quarterly* 2: 87-96.
- Hesselbart S (1977) Women Doctors Win and Male Nurses Lose. *Sociology of Work and Occupations* 4(1): 49-62.
- Heyman R, Shaw M P & Harding J (1983) A personal construct theory approach to the socialization of nursing trainees in two British general hospitals. *Journal of Advanced Nursing* 8(1): 59-67.
- Heyman R, Shaw M P & Harding J (1984) A longitudinal study of changing attitudes to work among nursing trainees in two British general hospitals. *Journal of Advanced Nursing Studies* 9(3): 297-305.
- Holley E (1987) *Timeline: Nursing*. London: Dryad Press Limited.
- Holloway I & Penson J (1987) Nurse education as social control. *Nurse Education Today* 7(5): 235-241.
- Holt R R (1972) On the Nature and Generality of Mental Imagery. In: P W Sheehan (ed), *The Function and Nature of Imagery*. New York: Academic Press. Pages 3-33.
- Horowitz M (1972) Image Formation: Clinical Observations and a Cognitive Model. In: P W Sheehan (ed), *The Function and Nature of Imagery*. New York: Academic Press. Pages 281-309.
- Horowitz M J (1978) *Image Formation and Cognition*, 2nd Edition. New York: Appleton-Century-Crofts.
- Hott J R (1977) Updating Cherry Ames. *American Journal of Nursing* 77(10): 1581.
- Hughes E (1971) *The Sociological Eye: Selected papers*. Chicago & New York: Aldine Atherton.

- Hughes E C (1951) Studying the Nurse's Work. *American Journal of Nursing* 51(5): 294-295.
- Hughes E C (1958) *Men and Their Work*. Glencoe, Illinois: The Free Press.
- Hughes E C, Hughes H M & Deutscher I (1958) *Twenty thousand nurses tell their story*. Philadelphia: J B Lippincott Company.
- Hunt J (1984) Do we deserve our image? *Nursing Times* 80(9): 53-55.
- Huntington M J (1957) The Development of a Professional Self-Image. In: R K Merton, G G Reader & P L Kendall (eds), *The Student-Physician — Introductory Studies in the Sociology of Medical Education*. Cambridge, Massachusetts: Harvard University Press. Pages 179-187.
- Hurley B A (1977) Problems of Interaction between Nurses and Dying Patients: Certainty of Death. In: M V Batey (ed), *Communicating Nursing Research. Volume 9: Nursing Research in the Bicentennial Year*. Boulder, Colorado: Western Interstate Commission for Higher Education. Pages 223-235.
- Hutcheson J D, Garland L M & Sowe L S (1979) Antecedents of nursing school attrition. *Nursing Research* 28(1): 57-62.
- Hyland M C, Millard J & Parker S (1988) How hospital ward members treat learner nurses: an investigation of learners' perceptions in a British hospital. *Journal of Advanced Nursing* 13(4): 472-477.
- Irwin J (1970) *The Felon*. Englewood Cliffs, New Jersey: Prentice-Hall.
- Jacob E (1989) Qualitative Research: A Defense of Traditions. *Review of Educational Research* 59(2): 229-235.
- Jacox A (1973) Professional Socialization of Nurses. *The Journal of the New York State Nurses Association* 4(4): 6-15.
- Jeffery R (1979) Normal rubbish: deviant patients in casualty departments. *Sociology of Health and Illness* 1(1): 90-107.
- Johnson M (1983) Some aspects of the relation between theory and research in nursing. *Journal of Advanced Nursing* 8(1): 21-28.
- Jones A H, ed (1988) *Images of Nurses — Perspectives from History, Art, and Literature*. Philadelphia: University of Pennsylvania Press.
- Kalisch B J & Kalisch P A (1983a) An Analysis of the Impact of Authorship on the Image of the Nurse Presented in Novels. *Research in Nursing and Health* 6(1): 17-24.
- Kalisch B J & Kalisch P A (1983b) Improving the Image of Nursing. *American Journal of Nursing* 83(1): 48-52.
- Kalisch B J, Kalisch P A & McHugh M L (1982) The nurse as a sex object in motion pictures, 1930 to 1980. *Research in Nursing and Health* 5(3): 147-154.
- Kalisch P A & Kalisch B J (1981) The Image of Psychiatric Nurses in Motion Pictures. *Perspectives in Psychiatric Care* 19(3 & 4):116-129.

Kalisch P A & Kalisch B J (1982a) Nurses on Prime-Time Television. *American Journal of Nursing* 82(2): 264-270.

Kalisch P A & Kalisch B J (1982b) The Image of the Nurse in Motion Pictures. *American Journal of Nursing* 82(4): 605-611.

Kalisch P A, Kalisch B J & Clinton J (1982) The World of Nursing on Prime Time Television, 1950 to 1980. *Nursing Research* 31(6): 358-363.

Kiger A M (1984) "Didn't You Always Want to Be a Nurse?" — A Proposal for a Study of the images of caring as perceived by entrants to nurse training. Unpublished MSc thesis, University of Edinburgh.

Kiger A M (1985) "Mirror, mirror on the wall..." — Some reflections on the image. In: The Nursing Studies Association, *The Politics of Progress*, Proceedings of the 19th Annual Study Day of the Nursing Studies Association, University of Edinburgh, 4 May 1985.

King C (1974) *People at Work: Nursing*. Glasgow: Blackie.

Kjervik D K & Martinson I M (1979) *Women in Stress: A Nursing Perspective*. New York: Appleton-Century-Crofts.

Kosslyn S M (1975) Information representation in visual images. *Cognitive Psychology* 7: 341-370.

Kuhlen R G (1968) Developmental changes in motivation during the adult years. In: B L Neugarten (ed), *Middle Age and Aging: A Reader in Social Psychology*. Chicago: University of Chicago Press. Pages 115-136

Lamond N (1974) *Becoming a Nurse — The Registered Nurses' View of General Student Nurse Education*. London: Royal College of Nursing.

Leininger M M, ed (1985) *Qualitative Research Methods in Nursing*. Orlando: Grune & Stratton, Inc.

Leventhal H & Israel S (1975) The Behavioral Measure: Conceptualizing, Researching, and Analyzing Psychological Factors in Nursing Research. In: P J Verhonick (ed), *Nursing Research I*. Boston: Little, Brown & Company. Pages 123-187.

Lewis B R (1980) Personality profiles for qualified nurses: possible implications for recruitment and selection of trainee nurses. *International Journal of Nursing Studies* 17(4): 221-234.

Lindauer M S (1972) The Sensory Attributes and Functions of Imagery and Imagery Evoking Stimuli. In: P W Sheehan (ed), *The Function and Nature of Imagery*. New York: Academic Press. Pages 131-147.

Llewelyn S P (1984) The cost of giving: emotional growth and emotional stress. In: S Skevington (ed), *Understanding Nurses: The Social Psychology of Nursing*. Chichester: John Wiley & Sons Ltd. Pages 49-65.

Luker K A (1984) Reading nursing: the burden of being different. *International Journal of Nursing Studies* 21(1): 1-7.

Lyall J (1986) 'We are not angels.' *Radio Times*, 8-14 November 1986: 93.

Maccoby E E & Maccoby N (1954) The Interview: A Tool of Social Science. In: G Lindzey (ed), *Handbook of Social Psychology, Vol. I*. Reading, Massachusetts: Addison-Wesley. Pages 449-487.

MacGuire J (1969) *Treshold to Nursing*. Occasional Papers on Social Administration No. 30. London: G Bell & Sons Ltd.

MacGuire J (1989) "The View is Fine from Fifty." Unpublished paper presented at 'Research in Nursing: Retrospect and Prospect', conference of The History of Nursing Group and The Research Society of the RCN, 12th September 1989.

Mackay L (1989) *Nursing a Problem*. Milton Keynes: Open University Press.

Mackay L (1991) Telephone conversation, 11 July 1991.

Mahone C H (1960) Fear of Failure and Unrealistic Vocational Aspiration. *Journal of Abnormal and Social Psychology* 60(2): 253-261.

Marshall J E (1989) Student attrition: Is lack of support a key? *Nursing Outlook* 37(4): 176-178.

McCall G J & Simmons J L, eds (1969) *Issues in Participant Observation*. Reading, Massachusetts: Addison-Wesley Publishing Company.

McCracken G (1988) *The Long Interview* (Qualitative Research Methods, Volume 13). Newbury Park: Sage Publications.

McKellar P (1972) Imagery from the Standpoint of Introspection. In: P W Sheehan (ed), *The Function and Nature of Imagery*. New York: Academic Press. Pages 35-61.

McPartland T S, Montague A, Whitmore A, Breed M L & Hinseth L (1957) *Formal education and the process of professionalization. Part V of A Study of the Registered Nurse in a Metropolitan Community*. Kansas City: Community Studies, Inc.

Measor L (1985) Interviewing: a Strategy in Qualitative Research. In: R G Burgess (ed), *Strategies of Educational Research: Qualitative Methods* (Social Research and Educational Studies Series: 1). London: The Falmer Press. Pages 55-77.

Meisenhelder T N (1977) An exploratory study of exiting from criminal careers. *Criminology* 15 (November): 319-114.

Melia K M (1981a) Student nurses' accounts of their work and training: a qualitative analysis. Unpublished PhD thesis, University of Edinburgh.

Melia K M (1981b) Student nurses' construction of nursing — A discussion of qualitative method. *Nursing Times* 77(16): 697-699.

Melia K M (1982) 'Tell it as it is'—qualitative methodology and nursing research: understanding the student nurse's world. *Journal of Advanced Nursing* 7(4): 327-335.

Melia K (1983a) Students' views of nursing — 2. Just passing through. *Nursing Times* 79(20): 26-27.

Melia K (1983b) Students' views of nursing — 3. Nursing in the dark. *Nursing Times* 79(21): 62-63.

Melia K (1983c) Students' views of nursing — 4. Doing nursing and being professional. *Nursing Times* 79(22): 28-30.

Melia K M (1984) Student nurses' construction of occupational socialisation. *Sociology of Health and Illness* 6(2): 132-151.

Melia K M (1987) *Learning and Working — The Occupational socialization of nurses*. London: Tavistock Publications.

Melosh B (1988) "A Special Relationship": Nurses and Patients in Twentieth-Century Short Stories. In: A H Jones (ed), *Images of Nurses — Perspectives from History, Art, and Literature*. Philadelphia: University of Pennsylvania Press. Pages 128-149.

Menzies I E P (1961) *The Functioning of Social Systems as a Defence against Anxiety*. Tavistock Pamphlet No. 3. London: Tavistock Publications.

Merleau-Ponty M (1962) *Phenomenology of Perception*. (Translated by C Smith.) London: Routledge & Kegan Paul.

Merton R K (1957a) *Social Theory and Social Structure*. New York: The Free Press.

Merton R K (1957b) Some preliminaries to a sociology of medical education. In: R K Merton, G G Reader & P L Kendall (eds), *The Student-Physician — Introductory Studies in the Sociology of Medical Education*. Cambridge, Massachusetts: Harvard University Press. Pages 3-79.

Merton R K, Reader G G & Kendall P L (1957) *The Student Physician — Introductory Studies in the Sociology of Medical Education*. Cambridge, Massachusetts: Harvard University Press.

Miller I M, Maclean P R, Turner E M, Tyler J, Walker M V & Closs S J (1988) *Jobfile 89 — The Comprehensive Careers Handbook*. London: Hodder and Stoughton.

Milne P & Duxbury L (1976) *Angels*. London: Robert Hale.

Mishler E G (1979) Meaning in Context: Is There Any Other Kind? *Harvard Educational Review* 49(1): 1-19.

Morris P E & Hampson P J (1983) *Imagery and Consciousness*. London: Academic Press.

Morse J M, ed (1991) *Qualitative Nursing Research: A Contemporary Dialogue*. Revised Edition. Newbury Park, California: Sage Publications.

Muff J (1982) *Socialization, sexism, and stereotyping: women's issues in nursing*. St. Louis: The C. V. Mosby Company.

Muff J (1988) Of Images and Ideals: A Look at Socialization and Sexism in Nursing. In: A H Jones (ed), *Images of Nurses — Perspectives from History, Art, and Literature*. Philadelphia: University of Pennsylvania Press. Pages 197-220.

- NBS (1990) *General Nursing — Working with People*. Edinburgh: Careers Information Service, National Board for Nursing, Midwifery and Health Visiting for Scotland.
- NBS (1991) *Nursing Opportunities in Scotland*. [Edinburgh: Careers Information Service, National Board for Nursing, Midwifery and Health Visiting for Scotland.]
- Neisser U (1972) Changing Concepts of Imagery. In: P W Sheehan (ed), *The Function and Nature of Imagery*. New York: Academic Press. Pages 233-251.
- Neisser U (1976) *Cognition and Reality*. San Francisco: Freeman.
- Neugarten B L (1968) Adult personality: Toward a psychology of the life cycle. B L Neugarten (ed), *Middle Age and Aging: A Reader in Social Psychology*. Chicago: University of Chicago Press. Pages 137-147.
- Oleson V L & Whittaker E W (1968) *The Silent Dialogue. A Study in the Social Psychology of Professional Socialization*. San Francisco: Jossey-Bass Inc.
- Olsson H M & Gullberg M T (1987) Nursing education and professional role acquisition. A longitudinal study of expectations and attitudes towards nurse role acquisition. *Nurse Education Today* 7(6): 270-277.
- Orton H D (1981) *Ward Learning Climate — A Study of the Role of the Ward Sister in Relation to Student Nurse Learning on the Ward*. London: Royal College of Nursing.
- Oxford Area Nurse Training Committee (1966) *From Student to Nurse: Training and qualification — A study of student nurses in training at five schools of nursing*. Oxford: Area Nurse Training Committee.
- Paivio A (1969) Mental Imagery in Associative Learning and Memory. *Psychological Review* 76(3): 241-263.
- Paivio A (1971) *Imagery and Verbal Processes*. New York: Holt, Rinehart and Winston.
- Parkes K R (1980a) Occupational stress among student nurses—1. A Comparison of medical and surgical wards. *Nursing Times* 76(44), Occasional Papers No. 25: 113-116.
- Parkes K R (1980b) Occupational stress among student nurses—2. A comparison of male and female wards. *Nursing Times* 76(45), Occasional Papers No. 26: 117-120.
- Perky C W (1910) An Experimental Study of Imagination. *American Journal of Psychology* 21: 422-452.
- Perry W G (1970) *Forms of Intellectual and Ethical Development in the College Years: A Scheme*. New York: Holt Rinehart and Winston.
- Polit D F & Hungler B P (1989) *Essentials of Nursing Research*, 2nd Edition. Philadelphia: J B Lippincott Company.
- Powney J & Watts M (1987) *Interviewing in Educational Research*. London: Routledge & Kegan Paul.

- Prophit P (1991) Nursing Studies. In: K Boehm & J Lees-Spalding (eds), *The Student Book 1992*. London: Macmillan. Pages 702-703.
- Psathas G (1968) The Fate of Idealism in Nursing School. *Journal of Health and Social Behavior* 9:52-65.
- Pylyshyn Z W (1973) What the mind's eye tells the mind's brain: a critique of mental imagery. *Psychological Bulletin* 80: 1-24.
- Pylyshyn Z W (1981) The imagery debate: analogue media versus tacit knowledge. *Psychological Review* 88: 16-45.
- Quint J C (1967) *The Nurse and the Dying Patient*. New York: Macmillan.
- Radio Times* (1991) [Mental Health Nursing advertisement] 9-15 November: 58-59.
- Raeburn M F (1990) The Male Student — Factors Affecting his Entry into Nurse Education: A Qualitative Study. Unpublished MEd thesis, University of Aberdeen.
- Reid N G (1985) *Wards in Chancery? Nurse Training in the Clinical Area*. London: The Royal College of Nursing.
- Revans R W (1964) *Standards for Morale: Cause and Effect in Hospitals*. London: Oxford University Press for the Nuffield Provincial Hospitals Trust.
- Richardson A (1969) *Mental Imagery*. London: Routledge & Kegan Paul.
- Richter L & Richter E (1974) Nurses in fiction. *American Journal of Nursing* 74(7): 1280.
- Rogoff N (1957) The Decision to Study Medicine. In: R K Merton, G G Reader & P L Kendall (eds), *The Student-Physician — Introductory Studies in the Sociology of Medical Education*. Cambridge, Massachusetts: Harvard University Press. Pages 109-129.
- Ryle G (1949) *The Concept of Mind*. London: Hutchinson.
- Salvage J (1983) Changing the Image. *International Nursing Review* 30(6): 181-182.
- Schedvin M B (1985) 'Why We Discontinued': An Exploration of Voluntary Discontinuation of Studies Among First Year Students at a College of Health Sciences. *Higher Education Research and Development* 4(2): 159-173.
- Schultz E D (1965) Personality traits of nursing students and faculty concepts of desirable traits: a longitudinal comparative study. *Nursing Research* 14(3): 261-164.
- Schwartz A H, Swartzburg M, Leib J & Slaby A E (1978) Medical school and the process of disillusionment. *Medical Education* 12: 182-185.
- Schwarzweiler H K (1960) Values and Occupational Choice. *Social Forces* 39(2): 126-135.
- Scottish Health Service Management Development Group of the Common Services Agency (1986) *"It's knowing that you're doing something to help."* Edinburgh: Scottish Health Service Management Development Group of the Common Services Agency.

- Segal B E (1962) Male Nurses: A Case Study in Status Contradiction and Prestige Loss. *Social Forces* 41: 31-38.
- Sellek T (1982) Satisfying and anxiety-creating incidents for nursing students. *Nursing Times* 78(48), Occasional Papers No. 35: 137-140.
- Seward J M (1969) The role of the nurse: perceptions of nursing students and auxiliary nursing personnel. *Nursing Research* 18(2): 164-169.
- Sheehan P W, ed (1972) *The Function and Nature of Imagery*. New York: Academic Press.
- Sheikh A A, ed (1983) *Imagery — Current Theory, Research, and Application*. New York: John Wiley & Sons.
- Shepard R N (1975) Form, formation and transformation of internal representations. In: R L Solso (ed), *Information Processing and Cognition: The Loyola Symposium*. Hillsdale, N. J.: Lawrence Erlbaum. Pages 87-122.
- Shepard R N & Podgorny P (1979) Cognitive processes that resemble perceptual processes. In: W K Estes (ed), *Handbook of Learning and Cognitive Processes*, Vol. 7. Hillsdale, N. J.: Lawrence Erlbaum.
- Shover N (1983) The Later Stages of Ordinary Property Offender Careers. *Social Problems* 31(2): 208-218.
- Silverman D (1985) *Qualitative Methodology and Sociology: Describing the Social World*. Aldershot: Gower.
- Simmons L W (1964) Images of the Nurse: Studies. In: L W Simmons & V Henderson (eds), *Nursing Research — A survey and Assessment*. New York: Appleton-Century-Crofts. Pages 173-223.
- Simms L M (1981) The Grounded Theory Approach in Nursing Research. *Nursing Research* 30(6): 356-359.
- Simpson I H (1979) *From student to nurse: A longitudinal study of socialization*. Cambridge: Cambridge University Press.
- Simpson R L & Simpson I H (1960) Values, Personal Influence, and Occupational Choice. *Social Forces* 39(2): 116-125.
- Skevington S, ed (1984) *Understanding Nurses: The Social Psychology of Nursing*. Chichester: John Wiley & Sons Ltd.
- Slater M (1979) *Career Patterns and the Occupational Image: A study of the library/information field* (Occupational Publication no. 23). London: Aslib.
- Snow-Antle S (1984) The image across the Atlantic. *Nursing Times* 80(2): 54-56.
- Spencer J (1983) Research with a human touch. *Nursing Times* 79(12): 24-27.
- Stein R F (1978) The Emerging Graduate. In: N L Chaska (ed), *The Nursing Profession: Views through the Mist*. New York: McGraw-Hill Book Company. Pages 21-34.

- Stern P N (1978) Stepfather families: integration around child discipline. *Issues in Mental Health Nursing* 1(2): 50-56.
- Stern P N (1980) Grounded Theory Methodology: Its Uses and Processes. *Image* 12(1): 20-23.
- Stern P N (1985) Using Grounded Theory Method in Nursing Research. In: M M Leininger (ed), *Qualitative Research Methods in Nursing*. Orlando, Florida: Grune & Stratton, Inc. Pages 149-160.
- Stern P N, Allen L M & Moxley P A (1984) Qualitative research: the nurse as grounded theorist. *Health Care for Women International* 5: 371-385.
- Stoller E P (1978) Preconceptions of the Nursing Role: A case study of an entering class. *Journal of Nursing Education* 17(6): 2-14.
- Strauss A (1970) Discovering New Theory from Previous Theory. In: T Shibusani (ed), *Human Nature and Collective Behavior — Papers in Honor of Herbert Blumer*. Englewood Cliffs, N.J.: Prentice-Hall, Inc. Pages 46-53.
- Strauss A (1987) *Qualitative Analysis for Social Scientists*. Cambridge: Cambridge University Press.
- Strauss A & Corbin J (1990) *Basics of Qualitative Research — Grounded Theory Procedures and Techniques*. Newbury Park, California: Sage Publications.
- Strauss A, Fagerhaugh S Y & Glaser B (1974) Pain: An Organizational-Work-Interactional Perspective. *Nursing Outlook* 22(9): 560-566.
- Strong P M (1979) *The ceremonial order of the clinic. Parents, doctors and medical bureaucracies*. London: Routledge & Kegan Paul.
- Thorner I (1955) Nursing: The Functional Significance of an Institutional Pattern. *American Sociological Review* 20(5): 531-538.
- Turner B A (1981) Some practical aspects of qualitative data analysis: One way of organising the cognitive processes associated with the generation of grounded theory. *Quality and Quantity* 15: 225-247.
- Verhonick P J, ed (1975) *Nursing Research I*. Boston: Little, Brown & Company.
- Ver Steeg D F (1968) The Fictional Nurse... Is She for Real? *Nursing Outlook* 16(8): 20-23.
- Walker M (1989) Analysing qualitative data: ethnography and the evaluation of medical education. *Medical Education* 23: 498-503.
- Waring A (1986) *Becoming a nurse*. London: Batsford Academic and Educational.
- Weiner C (1975) Pain assessment on an Orthopedic Ward. *Nursing Outlook* 23(8): 508-516.
- Wells H (1943) *Cherry Ames, Student Nurse*. New York: Grosset & Dunlap, Inc.
- White C M (1958) *Cadet Nurse at St Mark's*. London: Dragon.
- White C M (1961) *Junior Nurse at St Mark's*. London: Dragon.

- White C M (1963) *Nurse at St Mark's*. London: Dragon.
- White C M (1966) *Staff Nurse at St Mark's*. London: Dragon.
- White H (1990) *Children's Ward*. London: BBC Books.
- White H (1991) *Children's Ward—Deadly Enemies*. London: BBC Books.
- Wiener C L (1975) The burden of rheumatoid arthritis: tolerating the uncertainty. *Social Science and Medicine* 9:97-104.
- Williams J (1974) An Exploratory Investigation into Some Aspects of the Occupational Perceptions of Nurses. Unpublished MEd thesis, University of Aberdeen.
- Wilson H S (1977) Limiting Intrusion — Social Control of Outsiders in a Healing Community. An Illustration of Qualitative Comparative Analysis. *Nursing Research* 26(2): 103-111.
- Wilson H S & Levy J (1978) Why RN Students Drop Out. *Nursing Outlook* 26(7): 437-441.
- Windsor A (1987) Nursing Students' Perceptions of Clinical Experience. *Journal of Nursing Education* 26(4): 150-154.
- Wittgenstein L (1953) *Philosophical Investigations*. Oxford: Blackwell.
- Wolf T M, Balson P M, Faucett J M & Randall H M (1989) A retrospective study of attitude change during medical education. *Medical Education* 23: 19-23.
- Wright M S (1968) *Student Nurses in Scotland: Characteristics of Success and Failure*. Scottish Health Service Studies No. 7. N.p.: Scottish Home and Health Department.