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Voices from the past: professional discourse and reflective practice.

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In this chapter I intend to present and defend an argument about reflection and reflective practice that I have been exploring and developing for a long time. I have been a nurse for over 30 years; coming into an educational role in the late 1980s, my career could be said to run parallel with the development of reflective practice within the health professions. I, like Hunt in her chapter enthusiastically designed and ran modules using reflection as a medium for learning about professional practice in the 1980s and 1990s; I have made my limited contributions to the literature in this area and have been forced to reflect much more deeply and critically about my own practice as a result of doctoral study. My argument is as follows:

Firstly that professional practice is subject to a discourse, or a number of overlapping discourses that exert a powerful influence over our practice and its articulation. Secondly that reflection or reflective practice is now so embedded into our regulations, learning and teaching strategies and our assessment - particularly of fitness to practice - as to be indivisible from that practice. From this I conclude that the embodied nature of the professional discourse distorts the ways in which reflection and reflective practice are processed so that they tend to negative rather than positive outcomes. Many of the chapters – (e.g. Hunt and Boud) in this book are a testament to the challenges that are being made to this situation however I suggest that unless we understand, identify and shift the discourse we will struggle to change practice. In order to defend this argument I will draw on the literature, my thesis and my own personal reflective journey.

As a doctoral student I was interested in reflective practice, in particular the relationship between how professionalism was presented in academic and practice settings. Having a background in health care ethics I was inclined to ask questions like, ‘why do we do this?’ and ‘is this a good thing to do?’ In doing so I became puzzled and frustrated by the apparent inability of nursing and nurses to change, despite quite radical developments in curriculum design and professional organisation.

Streuburt and Carpenter (1999) suggest that, amongst other things, historical research may be useful because something from the past may help with the understanding the present or the future; this is very relevant to me as the performance of the collected health professions is seen as pivotal to managing the new ‘modernised’ NHS, and I am in a position of responsibility with regard to their education. Taking this to heart my focus became hospital based adult nursing from 1945 -1955, specifically exploring the discourse around education and the ways in which ‘good’ nursing was described and talked about. Seemingly regardless of the sex of the nurse, a number of gendered discourses around obedience, loyalty and vocation made up an image of the ‘good nurse’ in the post World War Two period. In order to conduct this research the literature drew me back a further 100 years to the emergence of nursing as an occupational group in the 19th century as the discourse formed then seemed to still exert a powerful influence on the behaviour and practice of nurses.

Whilst the research underpinning this chapter was conducted with nurses, I do not have any evidence that there is anything particularly unique or special about nursing as an occupational group, thus this argument may have a wider application.

Discourse as a starting point:

Many conceptual frameworks have been used to structure investigations into nursing: an early and very comprehensive study by Abel Smith (1960) is grounded in social and health policy;

Dingwall et al (1988) focus on socio-economic policy; Summers (1988) and Starns (2000), taking the first and second world wars respectively, present a convincing argument for the pervasive influence of the military in nursing's development; and Hallam (2000) offers a fascinating study of the way that nursing's image is manipulated and presented in literature and film. In addition, gender and class are significant influences which might suggest that a feminist approach was more appropriate (Davies 1995). However, I was interested in the ways in which nursing understood itself so, taking Hallam's (2000) three voices, 'autobiographical', 'professional' and 'public' I focused on the discourses that emerged from my data.

Many authors (see for example Sawicki 1991, Usher et al, 1997, Cheek 2000) argue for the pervasive and controlling effect of discourse. Cheek suggesting that:

'Discourses create discursive frameworks which order reality in a certain way. They both enable and constrain the production of knowledge in that they allow for certain ways of thinking whilst excluding others'. (Cheek, 2000:23)

Having identified the importance of discourse Foucault was chosen as a guide. In the 'History of Sexuality' Foucault (1979) proposes a dominant, powerful discourse about sex and sexuality. Of particular relevance to the development of nursing in the 19th century is his focus on the concept of family. Initially a middle and upper classes preoccupation, Foucault argues that from around the 1830s the middle class family model came to be seen as the:

'indispensable instrument of political control, economic regulation for the subjugation of the urban proletariat' (Foucault, 1979:122)

Hospital based nursing with its emphasis on control and order thrived within this discourse. Hospital development, particularly of the 'Voluntary' hospitals which were funded by local subscriptions (Abel –Smith 1964), was modelled on the middle-class family household, imported wholesale by the reforming new matrons. Thus the physician or surgeon was in charge with a 'good' strong woman in the role of matron to oversee the routine (Able –Smith 1960). A strict hierarchy existed below this where each more junior grade of nurse was more controlled by the grade above. It appears that good nurses, like good women, knew their place within this model and strove to maintain it.

The rise of capitalism and the growth of military power in the 19th century, of which hospital-based care is just one element, would not have been possible without the control of the working population as a key component of the economy. Foucault's (1979) argument is that the family model was the medium through which such powerful control was achieved.

It should be no surprise therefore that much of the literature presents the discourse on the growth of nursing in the 19th Century as one in which middle class women impress their (superior) values on working class people for the good of the nation. Brooks for example researches the role of the special probationer (these were more wealthy women who could afford to pay for their training and were often coached from the outset to be ward sisters and matrons):

'these women (elite, middle class nurses) could inculcate the working class recruits without becoming polluted by them, in much the same way that middle class women could undertake 'rescue' work with prostitutes without becoming contaminated.' (Brooks, 2001: 14)

However this does not fully explain the way that discourses around nursing developed. Foucault's notion is that discourse is not simply top down power, but permeates at all levels of society (Hoy 1986). This allows for a more holistic view which acknowledges the much more complex class divisions, power relationships and disciplines within nursing. Each grade of nurse within the hierarchy exerts a level of surveillance on the others and self regulation becomes inculcated into professional identity.

Further elements of discourse identified by Foucault include gaps and silences, resistant, control and finally 'bio power'. That is the regulation and control of the body, power over the individual body and over sexuality, and thus ultimately power over life and death. Ways in which 'bio power' works as a professional discourse can be seen in the way that cleanliness becomes the 'science of hygiene', promoted by Florence Nightingale (1992) and much discussed in early nursing texts (see for example Ashdown 1934). In addition Sawicki (1991:140) states:

'Bio power was without question an indisputable element of the development of capitalism. The latter would not have been possible without the controlled insertion of bodies into the machinery of production and the adjustment of the phenomena of population to the economic process.'

This resonates strongly with both the literature and my own data. Nurses no longer simply watched over patients, but are described by Maggs (1985) as managing time and controlling illness, much in the way that factories in the industrial revolution managed the process of production.

All of this was a revelation to me. My own reflective practice, and the practice I had encouraged with my students, tended to focus on the 'hear & now' of professional encounters. I had not really given much thought to unpicking what might lie behind.

The Good Nurse:

It became clear to me that exploring discourse offered an insightful framework through which to better understand nursing and nurse education. This was borne out as my data illustrated every aspect of discourse as presented by Foucault. In addition to the review of the literature which identified the discourses shaping nursing through the period 1850 -1950, three data sets were collected and analysed: a full life history of a single nursing career from 1932 -1974, interviews with nine retired nurses regarding their training between 1945 -1955 and documentary analysis of two journals (the Nursing Times and the Nursing Mirror) for the same period.

Analysis of this data, led me to conclude that the way nurses from the 1940s and 50s talked about nursing revealed the ambiguity that existed between the reality of their situation – giving intimate physical care to people who were not their kin – and the expectation that they were pure/ incorruptible. Taken together, the findings suggested that the way in which good nursing was talked about in the post World War Two period was derived from discourses originating many years earlier around 'woman' and 'middle class', Such that:

- femininity must be conveyed but without any overt sexuality
- motherly caring must be conveyed but without any apparent emotional engagement
- masculine/ military attributes such as discipline, punctuality and emotional distance must be developed without the nurse becoming masculine
- an intimate understanding of the physical self must be conveyed without any apparent

acknowledgement of the implications of such knowledge, or its relationship to emotional and sexual self.

I hope that I can illustrate these tensions by drawing on a very limited selection of the data.

The nurses talked about themselves as, girls rather than women:

'March 1948, my mother took me in a taxi and left me at the door and I was absolutely an innocent abroad, I had never worn make up, never left home straight from school'

This was typical of their memory of themselves as they entered nursing, but despite this they had a very subtle understanding of the expectations of their new status as nurses:

'You may have hit on something there I mean some of us were wild!! (Laughter) but I think we probably all came from lets say more or less the right background so we would not have got tarded up I mean when we went out we might have worn a bit of lipstick but eye shadow just wasn't...' (trails off to silence)'

This reminiscence was made with humour and reflects their childish innocence. However the fine line between wearing lipstick and eye shadow as a demarcation of respectability is just one of many examples of their clear understanding that the aspiration of nursing to be a middle class female occupation required much of their femininity to be hidden. This quote also serves to illustrate the ways that gaps and silences work in the discourse along with phrases used when avoiding discussions around boyfriends - *'you never thought of'...* *'you would not have dreamed of'*. These silences hint at a hidden but implicit sexual self which has no place in the overt discourse around good nursing. As all but one of my nurses married, mostly within months of completing their training, this apparent lack of self awareness is patently not true!

A lack of understanding of these 'rules' could lead to almost certain dismissal:

'Women were being called up, she was an actress , or she would have liked to have been, so she was sent to a munitions factory , but she decided she would like to do nursing - she 'heard the call' (laughter) very dramatic! we all arrived at PTS[1] we all had our hats on well her hat was a particularly soggy one she arrives like this with all her makeup on - very glamorous, and was promptly sent to get washed and when she came back - every eyebrow, everything went - this pale completely naked face - she did not last long! (Laughs)'

Pre Training School allowed nurses to learn to wear the uniform correctly and to practice cleaning and cleanliness which were very important within the ward routine:

'It was a hard slog [on the wards], and we used to mop the floors and everything like that . . . and the sterilisers and that were either brass or copper and they would have to be perfect, and it had to be spotless, all the urinals were glass and had to be without stains'

Words like 'spotless and 'stain free' occur regularly within the data, visible 'dirt' indicating contamination and lack of control over an unpredictable, disease ridden environment. Despite

engaging in this cleaning work, nurses were expected to always look clean themselves. The meticulous detail of this was captured in one nurse's recollection of the ritual of apron changes:

'and of course we went on the ward at 7.30 and at 9.15 and 10.15 had two apron breaks where you went for a cup of tea and changed your apron from the dirty work so you came back on again with a clean apron so your dress was never actually in contact with the patient- [they] had a big bib and came right round and were starched'

The uniform was a source of undisguised pride for all of the nurses I met and wearing it correctly was clearly very important. It seemed to act as a metaphor for 'moral cleanliness' as well as enabling physical cleanliness. In uniform they were no longer just young women but nurses. It gave emotional and physical protection, status & esteem, 'hid' their individuality and presented an outward declaration of their allegiance to the hospital rules. In uniform they could be 'close' to patients performing the motherly nurturing acts of washing, feeding and protecting, whilst remaining 'distant' as a fellow human being. On reflection, this illusion of closeness resonates with my own nurse training in the 1970's when it was made clear to us that 'getting too close' to patients was personally dangerous and professionally deviant.

In this post World War Two period of my research the importance of the uniform appeared to verge on obsession, with one nurse being publicly reprimanded for coming on duty with her sprained ankle in plaster – not because she was unfit to be on duty, but because the plaster meant that she could not wear the regulation shoe and stocking correctly on that leg!

Unquestioning obedience was essential to the smooth running of the hospital system. A particular reminiscence left me reflecting on how skilfully the education system inculcated this into the recruits:

'we were taught how to do them [injections] with oranges and then to inject ourselves and then each other with sterile water –this would not be allowed now - we used to have to pass Ryles[2] tubes! We used to have to pass them on each other - if you think about health and safety'

Doing an injection and passing a Ryles tube both take a steady hand and a fair degree of self confidence; both techniques if done incorrectly can cause quite serious damage. Thus the new recruits were 'tested' in the safe environment of the nursing school, passing this stage before they were allowed to practise on patients. In addition both activities require the nurse to inflict pain and discomfort on the patient, thus they run counter to any romantic images of nursing which the new recruits may have arrived with.

Clearly student nurses who did not have the courage to perform these activities in the safety of the classroom were unlikely to succeed in practice and so this was an important practical test. However exposing the student to such procedures was equally important as another effective filtering process. Agreeing to perform these tasks on a fellow student and allowing an inexperienced person to do it to you would only happen in a situation where there was an absolute obligation to obedience and no opportunity to refuse. If a recruit was unable to both do and experience such procedures it signalled either weakness or deviance.

Having passed the many social and practical tests set in the Pre Training School the young recruits spent the next three years rotating through day and night duty nursing experiences and living in the nurse's home. For those who thrived the hospital routine controlled everything

including the patient's day. As I was analysing the data I kept returning to one particular reminiscence, reflecting on what it meant to me and to my research:

'yes they were long hours the nursing was a very physical job, we did so much more for patients and they were in hospital longer, we did everything for them bathe them absolutely everything, they were expected to be this patient in this bed, which really for me was easy because that was how I saw life being very ordered, the pillow opening had to be away from the door and the lockers had to be tidy I was a very well disciplined nurse I do not find it easy to work where beds are untidy and people sit on the beds - - - cannot take away the skill of making a patient comfortable and putting the patient first, we cut their nails, we shaved them, we did everything for them'

I did not detect any tension between competing concepts in listening to this memory; the nurse appeared confident and proud of this as a positive and unremarkable assertion of her identity and role as a nurse at that time and her continued identification with this as an example of good nursing. The person - 'this patient in this bed' is expected to conform to having every activity of his or her life controlled - from nail cutting to the juxtaposition of pillow, bed and locker. The patient is beholden to the nurse for the performance of all bodily functions and can only perform these in the ritualised ways permitted within the hospital, to which the nurse is the gatekeeper. Even personal untidiness is not allowed as this will disrupt the orderly view of the ward; and yet the nurse declares that this is illustrative of nursing's goal of 'making a patient comfortable and putting the patient first'.

It appears that this fragmented, or task oriented approach to the patients' day meant that patients were simultaneously the precise object of the orderly routine and as individuals totally irrelevant. The regulation of human existence was the work of the nurse; her role to ensure that the patient's physical needs are attended to, not as natural functions but as nursing procedures. The combination of the apprenticeship model of training and living in the nurses home meant that these values were reinforced at every turn.

The women I interviewed seemed to have achieved their complex and confusing metamorphosis into nurses despite their youth, innocence and limited life experience. On the one hand they displayed the apparently innate womanly ability to 'care' and quickly acquire nursing skills, but on the other they knew that if they displayed weakness, became emotionally or sexually involved with their patients or revealed too much of their individuality they would be singled out as unsuitable.

They appeared not learn to nurse, but became nurses and in doing so accepted an alteration and suppression of self. This is manifested in the subjugation to the hospital routine and to the acceptance of a position of power over individual patient's daily routine, whilst having no power over decision making in policy or practice. Nurses, in line with Foucault's concepts of disciplinary control (1991), did the 'work' of surveillance and control over individual patients and over their illness, whilst simultaneously doing the same for themselves and their profession in the same way that mothers do with their families within society.

Listening to the nurses talk, and then reading their transcripts left me reflecting on the strangely dated discourse that was being presented. This was echoed in the analysis of the nursing press at the time. For example when the Royal College of Nursing commissioned the Horder Report (1943) which declared that:

‘.....the training of nurses in this country could be developed into one of the great national education movements for women’ (p5)

It was met with vitriolic dismissal in letters from ordinary nurses as well as editorials and papers by educational leaders.

The characterisation of the ‘good nurse’ that I felt I had identified in the 1945 -1955 period seemed to typify the philanthropic women described by Brooks (2001) of the late 19th and early 20th century. Women who engaged in Christian work supporting the sick poor and who formed the early ranks of nursing pioneers such as Florence Nightingale (Woodman –Smith 1950) and Sister Dora (Manton 1971). However they seem strangely dated when applied to 17 and 18 year old grammar school girls in the post Second World War period.

From blind obedience to reflective practice:

These findings suggested that the nurses’ self conceptualisation, emotional distance and absolute obedience are entirely congruent with the discourse. Furthermore, that the apprenticeship system, combined with the ‘raw materials’ of the recruits and the hospital –based care system, effectively nurtured this discourse well beyond its useful lifespan.

Reflecting on these findings may have relevance for current professional practice and education. Whilst nursing may have some unique characteristics, much of the socialising into the professional role is shared by other health professionals, social workers and teachers. All seem to be permanently locked into a situation where practice, education and policy struggle to co-exist and current practice is always open to criticism for being either out of date or too radical.

The initial training for many ‘caring’ professions within the United Kingdom, for example Social Work, Teaching and Health Visiting moved into Higher Education long before nursing, as did many of the Allied Health Professions. Despite these differences it is now expected that all health and social care professionals are educated in Higher Education. I would like to argue that one of the major, significant developments of professional discourse that has been enabled by this transformation is the emergence of reflective practice as the process through which professionals are expected to mediate their learning and personal development.

Whilst its origins are much earlier, reflection and reflective practice was introduced to the professional discourse in the 1980’s through the seminal work of people such as Schon (1983) and Boud et al (1985). In nursing extensive phenomenological research (see for example Benner 1984, Benner et al 1996 and Macleod 1996) has confirmed reflective practice as a feature of expert (and thus good) nursing. This offers a wonderful, radical antidote to the unquestioning obedience of the past. Reflection offers a supportive model for thinking about what we are doing and why, and a strategy for improvement.

It is therefore inevitable that reflection became embedded into the learning and teaching ethos of professionally regulated courses. Whilst many authors (see for example Burns and Schultz 2008), have expressed doubts regarding the wisdom of formally assessing reflection, the currently favoured ‘alignment’ model of curriculum development (Biggs 2003) makes it extremely difficult to make the development of reflective skills a core element of the curriculum design without it being overtly assessed. Despite my own reservations regarding the ethics of assessing student reflections (Hargreaves 1997, 2004) even I would struggle to envision a curriculum where reflection was central to the learning strategy but absent in the design of

assessment.

So: as we have moved from the hospital based apprenticeships of the post World War Two era to the Higher Education courses at present, reflection has become the process through which students' engage with their understanding of themselves and their practice. Alongside this professionals are now expected to have a very different relationship with the people they care for.

Within one generation there has been a complete reversal of the emotional expectations of professional people. The gaps and silences in the discourse I explored showed how nurses had learned to embrace a situation in which they did not get too close to patients, focused only on the physical manifestation of their patient's needs and did not acknowledge their own weaknesses; although I trained many years later that expectation remained. This contrasts remarkably with the current professional literature on caring and emotional labour.

The change in emphasis regarding 'care' can be dated in the literature from the 1960's and suggests that caring *for* (i.e. surveillance and control) is no longer sufficient and that caring *about* (i.e. emotional engagement of self) is an essential part of professional care [examples of this extensive literature are Noddings 1964, Benner and Wrubel 1989, Swanson 1991]. Nursing is described as 'emotional labour' (James 1989, Smith 1992) in which there is an expectation that nurses draw upon their emotional selves in order to care for patients.

Taken together with reflective practice, all of these concepts contribute to a current discourse in which the emotional engagement of self (an expectation that one understands, cares about and overtly expresses empathy with the social and psychological needs of the patient), the imperative for continuous self-reflection and for academic improvement are embedded in educational programmes and literature. Two quotes serve to illustrate this change.

Taken from the 1946 probationer's notes for St George's hospital (cited in Rivett 2006):

'... she must be observant and possess a real power of noting all details about her patient. She must be promptly obedient and respect hospital etiquette A nurse's manner to her patient should be dignified, friendly and gentle, but no terms of endearment must be used. She should surround herself with mystery for her patient and never discuss her own private affairs.'

By contrast Johns (2004:3) describes reflection as:

'being mindful of self, either within or after experience, as if a window through which the practitioner can view and focus self within the context of a particular experience in order to confront, understand and move towards resolving contradiction between ones vision and ones actual practice.'

In which his vision is to 'ease suffering and nurture growth through the health –illness experience'.

The first quote relates to nursing exclusively, whereas Johns writes for an audience of any practicing professional. Clearly expectations have changed greatly from one in which the worker creates a barrier between his/herself and the patient and the second in which nothing less than

total engagement is acceptable.

The research underpinning this chapter suggests that throughout nursing's development the dominant discourse has reinforced a distorted view of womanhood where the 'desirable' aspects were promoted and the undesirable suppressed. Amongst the desirable aspects were obedience and loyalty as well as hiding, or suppressing one's own thoughts and feelings. From this I think it can be argued that 'caring about' and emotional labour are moderated in nursing through the dominant discourse around 'altered womanhood' outlined earlier: consequently the imperative that nurses embrace and positively use their emotional selves in their practice may be just as controlling as being required to suppress it.

At this point the reader may feel I am overstating my argument – I don't think so: One of the questions I asked the elderly nurses I interviewed was what they thought being a 'good' nurse meant in their time. This either puzzled them – they struggled to find a vocabulary, or they laughed and said that they never ever felt, or were encouraged to feel, that they were good enough. Forty years later my experience of asking practitioners to recount a critical incident illustrative of their practice yielded wave upon wave of negative memories [for example -'my worst shift' 'the baby died' 'the doctors were wrong but no one stood up to them']. Given the freedom to reflect about themselves and their practice few practitioners recount instances which portray themselves or their colleagues in a positive light. In my experience this phenomenon seems to transcend the gender of the writer and may cross professional boundaries too.

In the study period nursing discourse mirrored the dominant (gendered) discourses of the day, expecting nurses to be unquestioningly obedient and to have respect for the authority of the medical staff, matron and the hospital. My reflections lead me to believe that professionals today are equally coerced into obedience by emotional manipulation and the tyranny of being required to 'care' in systems which, despite the rhetoric of current policy are no more people centred than in the past. Furthermore for nurses, in the past the stressful environment in practice was tempered by the protective buffer offered by living in the nurses' home; they had no need to worry about laundry, bills, food or shelter and had a ready –made close knit group of people with whom to share their experiences. None of these privileges exist for nurses today and there is evidence that poor morale is prevalent as can be seen in research on bullying (Randle 2003a), poor self esteem (Randle 2003b) and burnout (Deary et al 2003)).

Reflection, reflective practice and the use of one's emotional self in caring do not have to be a tyranny. Benner (1984) and Benner et al (1996) both demonstrate forcibly how reflection on practice can be a positive, life affirming process, which highlights expertise and good professional care. In this volume Boud suggests relocating reflection in practice, and Hunt refers to the need for 'unfettered places' in which to be free to reflect. However, the continuing discourse within nursing specifically and possibly also in other 'caring' professions is suspicious of any activity that is not controlled and measured. The overriding discourse encourages practitioners to identify what they have done wrong and to see themselves as failing, rather than build on and celebrate their strengths.

Conclusion:

The research on which this chapter is based was initiated following frustration at sustained criticism of nurse education for producing the wrong sort of nurses. The findings suggest that nursing is subject to powerful discourses which are predicated on values of service and

obedience and an adaptation of more general discourses around womanhood. The suggestion from the findings is that reflective practice absorbs the discourse (which is slow to change) and resists attempts to challenge its central assumptions. Furthermore, this phenomenon is unlikely to be exclusive to nursing.

Policy directives which tell practitioners what they should do and how it should be done, including the requirement to demonstrate reflective practice, seem unlikely to yield the changes required unless there is a massive paradigm shift. Professional lifelong learning needs to have a much clearer vision of what is needed to bring about change and to have realistic expectations of the extent to which this threatens the central discourses that control practitioners. Most professions would claim that the move to a Higher Education setting with its philosophy of giving practitioners knowledge and confidence means that its members are no longer simply obedient but are ready to be professionally accountable. However the bulk of professional practice is still learned through placements with supervision from qualified educators in a real practice situation. The control over moulding the character and behaviour of students that this creates will tend to override any theoretical model which the students have been presented with in an academic setting. Bolting an academic education onto what is, in practice if not in name, an apprentice system is unlikely to yield the radical change that successive governments and education leaders' desire.

It therefore seems reasonable to assume that the discourse that students are exposed to during their practice experience will exert a disproportionate influence on their experience and socialisation into the norms of their profession. Understanding this discourse, and the tensions it creates for students who are torn between the real and espoused experience of practice is essential if professional educators are to effectively support their reflection and improve practice.

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[1] Pre Training School

[2] A 'Ryles' tube is a thin plastic tube passed through the nose into the stomach, in order to drain the stomach contents, and to 'rest' the gastro –intestinal tract. Having one passed is very uncomfortable, and carries the danger of aspiration pneumonia if the tube is inadvertently passed into the lung by mistake.