An Ethnographic Exploration of Novice Nursing Students' Clinical Learning Experiences: Backstage Realities

by

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DEDICATION

This thesis is dedicated to all of the nursing students who participated in this research study. Without your willingness to share your time, experiences, and feelings about the educative process this thesis would not have been possible.

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ABSTRACT

This study explored the learning experiences of generic baccalaureate students in an initial clinical course. Since learning itself is difficult to articulate, the ethnographic method of combining interview, observation, and artifact collection was adopted for the research. Observations occurred in the background environment of class, laboratory, and clinical areas. Goffman's metaphors of "frontstage" and "backstage" presentations of the self were used as a thread that pulled through all of the themes to assist in identifying the locale of the learning experiences. Through the use of feminist, critical social, and poststructural theories, the themes derived from the students' learning experiences were examined. The themes of "being watched and marked", "going over things in my mind", and searching for "comfort" were identified in the data. The theme "being watched and marked" describes the frontstage realities of student learning experiences. "Going over things in my mind" is the theme that describes the backstage processes of learning. The umbrella theme of searching for "comfort" describes the various conditions that influence students' learning experiences. The analysis of these themes serves a dual purpose. It provides an opportunity to deepen understandings gained from the illumination of the lived experiences of the students, and it serves as a forum to discuss directions in alternative curricular development in nursing education aimed at enhancing the educative process.

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CHAPTER I

Introduction

> If we want to understand what it means to be a teacher or a student of nursing, then we must conduct research that will enable us to hear those voices (Diekelmann, 1989, p. 35).

The following study is my attempt to meet the challenge issued in the above statement as it relates to nursing students. This thesis is the result of a feminist ethnographic exploration of the learning experiences of a group of women nursing students in an initial clinical course. My choice of feminist ethnography as a research method was influenced by the nature of the research. Ethnography uses an emic, or insider approach to studying how knowledge is organized within specific cultures (Parse, Coyne, & Smith, 1985).

Ethnographic research recognizes that culture (in this case the culture of nursing students) is a system of knowledge used to interpret experience and generate behavior (Spradley, 1979). The linguistic expressions used during social interactions are the building blocks of meaning that construct this cultural knowledge (Aamodt, 1991). As both a nurse educator and a student, I have come to appreciate the complexity of people's lives and that to place demands on their time to participate in research in a highly stressful time, such as an initial clinical course, meant that reciprocity was necessary. The ethnographic method of research, combining observation, interview, and artifact collection, provides opportunity for rapport building, sharing of life experiences, and self-reflection for both the participants and the researcher.

I entered the research field curious to discover how student nurses use their knowledge in an initial clinical course to organize their behavior and how this knowledge came to be developed. It is through understanding and deriving knowledge from their learning experiences that transformation in nursing education can occur.

Assumptions Entering the Research

It must be acknowledged that my beliefs about nursing and the context in which I present myself does influence the presentation and interpretation of the research findings. I am part of the social world in which I do research and the choices that are made within a research project are related to the social world within which I live. The ideas of the researcher will pervade the research whether it is desired or not (Aamodt, 1991). I acknowledge up front that I exist as a white, middle-class, female nurse educator and carry with me into this research the privilege of this position. I attempt to recognize and take into account how my life and the lives of the students in the study are "mediated by systems of inequity such as classism, racism, and sexism" (Lather, 1992, p. 87).

I believe that minimizing the differences between the researched and the researcher in a non-hierarchical way is one of the distinguishing features of feminist research (Williams, 1995) and an assumption underpinning this study. That is, I did not want to undertake this study in the conventional way of observing or interviewing 'subjects'. But in saying that, my assumptions as a researcher did have impact simply in the choice of focusing on the "backstage" realities of novice nursing students' clinical learning experiences. I recognize this disparity, that is, it was I who chose the specific research arena and methodologies. That

aside, I wanted to allow both myself and the participants to behave in a manner as usual as possible during their clinical experiences.

According to Goffman's (1959) work on the presentation of self in everyday life, people present multiple realities, two of which are "frontstage" and "backstage". I came into this research with the assumption that the "backstage" realities of an initial clinical course would better inform me of the experiences nursing students confront in their education. The ethnographic method provides the opportunity to explore the relationship between what people do and what they say they do within a cultural context. This is not to say that some "frontstage" presentations were not captured, just that the study focused in a greater way on the backstage realities of student experiences. These accounts (researcher observations and reflected accounts by students of their activities) stand beside each other as constituents of the ethnographic field data.

A feminist ethnography in itself implies a political position in relation to the social production of knowledge (Williams, 1996). Feminist research "assumes that ways of knowing are inherently culture bound and that researcher values permeate inquiry" (Lather, 1992, p. 91). Nursing knowledge, Hagnell (1989) contends, is based in part on the location of nursing as an undervalued, gender-defined occupation in a patriarchal society. This location helps define the lack of status that is ascribed to nursing knowledge (which in turn is intimately linked to women's knowledge) that develops from the lived experiences of nurses. The assumptions that are embedded in this research study question the issues of power and knowledge in nursing education that construct the

cultural realities of this group of women. I write from one standpoint (whether intentionally or unintentionally) that, predominately, nursing education "is based on control and conformity of the human mind and spirit" (Bevis, 1989, p. 38). The historical ties of nursing education to the ideology of dualism - or the separation of fact from value or meaning - still remain. This is not to say that attempts are not being made within nursing education to transform student-teacher relationships, but there still exists an unbalanced power structure that does not support mutual participation of teachers and students in the teaching-learning process.

This study shares the individual and collective experiences of a group of nursing students at a particular point in their educational story. Although these experiences may not represent all nursing students experiences, I suspect that some of the stories the students share related to their education may be familiar to many nurses as well as nursing students. This study provides a forum for student voices to be heard and as a medium to use what is heard to effect change in nursing education.

Need for the Study

One of the most anxiety-producing aspects of student nurses' clinical experiences is the initial clinical experience (Kleehammer, Hart, & Keck, 1990). To date, there is no nursing ethnographic research exploring student learning experiences in an initial clinical course, although there are ethnographic studies completed with other cohorts of students (Mackenzie, 1992; Wilson, 1994). As well, there is relatively little research related to initial nursing clinical courses using other research methodologies. Beck's (1993) phenomenological study of nursing students' initial clinical experience does, however, explore the

experiences of students during the first day of clinical and provides insight into the world of nursing students in a previously undiscovered way.

Another reason for implementing this particular type of research is to explore student learning from feminist standpoints. Nursing education traditionally functions within a conventional behaviorist pedagogy rather than considering alternative educative approaches that foster dialogue and are "grounded in the day to day experiences of clinicians, students, and teachers" (Diekelmann, 1993, p. 301). Feminist pedagogy examines teaching and learning activities from the perspective that much of what is identified as important to learn comes from a predominantly male experience of the world (Chinn, 1989). In this specific case, much of nursing knowledge has emerged from the sphere of medicine and psychology. Research is needed that examines the forces that influence nursing students' learning and nursing education from alternative perspectives. There is an agreed upon agenda in both ethnographic research and feminist research to challenge the perceived superiority of scientific knowledge over everyday knowledge (Williams, 1996).

In addition to the aforementioned reasons for conducting this research, I believe that nurse educators (myself included) may benefit from the examination of issues students raise relating to an initial clinical course and use the information to not change only teaching approaches, but to provide impetus for curricular change. The themes that emerge from the data will be analyzed from the perspectives of feminist, critical, and poststructuralist theory. Feminist theory places gender at the centre of the research, and critical theory recognizes the

"hidden sources of coercion, power-over, and domination . . . that are embedded in the everyday lived experience" (Thompson, 1987, p. 33). The use of poststructuralist thought encourages us to look at the forces that limit what we can know and challenges us to identify patterns that clarify individuals' personal experiences (Dzurec, 1989).

There has been a movement to revolutionize or transform nursing education so it educates students who become caring and creative critical thinkers recognizing the diversity of individuals and families (Tanner, 1990a). But are these changes occurring within schools of nursing? This research will shed light on the valuable resource that students can be to inform change within nursing education.

CHAPTER II

Methodology

> The choice of a research discourse is never simply the expression of an intellectual preference: it is not independent of historically concrete cultures and practices. Research studies are historical artifacts. (Packwood & Sikes, 1996, p. 337)

The concepts of method and methodology are interdependent (King, 1994). The methodology chosen for research guides how the research method shall proceed, links the researcher to a philosophical stance, and drives the assumptions of the research (Campbell & Bunting, 1991). For this research, the theoretical principles of feminist research were used to guide the ethnographic research process as well as provide a woman's lens for viewing the research data. In addition, the works of poststructural theorists are used to highlight the power issues which exist within nursing discourse. The ways in which the hegemonic nature of nursing knowledge is gendered will also be explored. Critical social theory offers perspectives on the historical, racial, and cultural context of the generation of knowledge. Lastly, the more traditional sociological work of Goffman is used to provide a greater depth of meaning to the focus on the backstage realities of learning at a micro level of analysis.

Evans (1993) contends that nursing research using multiple paradigms will help nursing evolve. The methodologies I use share commonalties and differences and, although there can be no one "best" methodology (King, 1994), each can be used in creative ways to provide context for this research.

Guiding Perspectives

Feminist Theory

"To do feminist research is to put the social construction of gender at the center of one's inquiry" (Lather, 1991, p. 71). Feminist research is grounded in women's experiences (MacPherson, 1983), and is intimately connected with the political (Chinn, 1989). "The overt ideological goal of feminist research in the human sciences is to correct the *invisibility* and *distortion* of female experience in ways relevant to ending women's unequal social position" (Lather, 1991, p.71).

Feminist theory identifies that socially legitimized knowledge is constructed by dominant social groups and that general social knowledge has been generated without asking questions from the perspective of women's lives (Harding, 1991). Knowledge given the highest status today is scientific knowledge and is created by and for male interests but it is only considered legitimate because men have had the power to label it as such (Hagnell, 1989). This process of legitimization is guarded by the scientific community and the subjective control of research approval and/or dissemination is objectified through criteria controlled by this same community (Duffy, 1985). In essence, what is deemed contrary to the status quo can be rendered invisible and the flow of knowledge halted by those who control decision-making power. Hagnell (1989) contends that nursing has relied heavily on scientific knowledge to improve their social status as a profession and has only lately questioned the underlying assumptions of the scientific method and its value in seeming to legitimize nursing knowledge.

What then are the underlying assumptions guiding this new generation research? Foremost, feminist principles facilitate the embracing of subjectivity and avoid the term objectivity (Keddy, 1992). Feminist literature provided research principles that I used to guide this research process.

1. Feminist research recognizes the existence of ideological, structural, and interpersonal conditions that oppress women (Duffy, 1985). Nursing, a profession largely consisting of women, has a responsibility to address the concerns of women. All women share a set of common experiences derived from their mutual oppression as women (Stanley & Wise, 1990). However, these authors are quick to point out that this is not to say that we share the same experiences, rather, that within the social context of women's lives, forms of oppression exist. Roberts (1983) notes that nursing education is oppressed by powerful societal forces and that nurses subsequently exhibit characteristics of other oppressed groups. She goes on to say that in an effort to liberate nursing from medically-centered thinking, current feminist thinking is needed.

2. The feminist research approach is characterized by the following activities: interaction between the researcher and the participant, a nonhierarchial relationship between the researcher and the participant, an opportunity for expression of feelings, and a concern for values. One of the propositions of feminist research is that it is carried out *for* women rather than *on* women (Stanley & Wise, 1990). The intention of feminist research is to "minimize the tendency in all research to transform those

researched into objects of scrutiny and manipulation" (Acker, Barry, & Esseveld, 1983, p. 425).

3. The study should have the potential to help participants as well as researchers. Feminist research attempts to improve the lives of all women and people (Evans, 1993). Feminists note that the goal of feminist writing is to not only describe and interpret phenomena of women's lives but also to raise consciousness and bring about change in women's lives (Fonow & Cook, 1991; Hall & Stevens, 1991).

4. The research is focused on the experiences of the woman. The research is defined as having to do with how a woman lives through the topic of the research (Duffy, 1985). Feminist research acknowledges the existence of multiple realities and does not try to separate women's experiences from the contexts in which they occur (Hall & Stevens, 1991).

Feminist research is not only about the participants' experiences but about my experiences as a researcher. Feminist research principles require reflexivity or a conscientious reflection by the researcher on assumptions, actions, and situatedness in the research. Reflexivity also means that the researcher must critically examine and explore the nature of the research process (Fonow & Cook, 1991).

In the next section, components of poststructuralist theory and postmodern feminism that informed the research experience are described.

Poststructuralist Theory/Feminist Postmodernism

Poststructuralism functions as a "de-centering" discourse which challenges us to think about who we are and how we are

constructed/constituted (Kohli, 1991). It asserts that the epistemological foundations of western thought that are grounded in the beliefs of rationalism and dualism (the division of reality into two irreconcilable parts) must be displaced and that a "different way of describing human knowledge and its acquisition must be found" (Hekman, 1990, p. 1). It may, at first glance, appear that feminist and poststructuralist research are at odds with each other. Feminism considers it necessary that gender be at the center of research and postructuralism encourages a decentering process within research. However, Hekman (1990) suggests that feminist critique supplements the postmodern critique of the Enlightenment (a philosophical movement of the 18th century, characterized by belief in the power of human reason) (Random House Unabridged Dictionary, 1993). Hekman (1990) states:

> The postmodern critique of Enlightenment dualism and the privileging it entails, however, is incomplete without the feminist contribution to that critique. The postmoderns see the error of Enlightenment dualism but the feminists complete this critique by defining those dualisms as gendered (p. 8).

Sands and Nuccio (1992) have summarized five themes that occur in poststructuralist writings that are used in association with feminist principles to guide the research process.

1. A criticism of logocentrism (the belief that there is a fixed, singular, logical order) and the notion that there are "essential" meanings in the world. Poststructuralists criticize logocentric thinking by presenting meanings as being historically and contextually bound. Logocentrism relies on dichotomies (e. g. subject/object) for the

production of knowledge but poststructuralist theory acknowledges that contradictions exist in the world and that there is no universalizing truth to be found.

2. That "difference" is not thought of in terms of binary opposites (e. g. male/female) but that "difference" is the residue of meaning that does not fit into dichotomous categories.

3. That one way to analyze texts is through deconstruction. Deconstruction of a text means that the given constructs are not accepted at face value but the text is viewed in relation to the social, political, and historical context. One of the aims of poststructuralism is to

> challenge the authority of established discourses by 'deconstructing' the linguistic organization of the subjective self and social institutions, identifying how signifying and discursive practices empower and privilege certain individuals, groups and forms of social life. (Mitchell, 1996, p. 202)

Poststructuralists view meaning that is produced within language as multiple, unstable, and open to interpretation. In this sense, discourse and readers are viewed as situated in, rather than neutral to, the text. There is an emphasis on the energy and "fundamental undecidability" of language and meaning (Mitchell, 1996). Weber (1986) describes language as being populated-overpopulated-with the intentions of others. She describes language as not being neutral to, but inseparable from, the lived experience and the development of how people create a distinctive voice.

4. That there are multiple discourses present in any text. However, there are many perspectives that have been silenced throughout history. Foucault's (1980) work related to power and organization in society focuses in on discourse. Foucault describes power as not belonging to an individual or a group but that it is a force. "It is neither given nor exchanged nor received but rather that it is exercised, and that it exists only in action" (p. 89). He contends that discourses which are 'heard' are intimately associated with power. It is power that determines what can and will be known. Because power and knowledge are so closely linked, Foucault uses the term "power/knowledge" to describe this concept.

5. That there are multiple, subjective positions. That is, depending on the context, the subject is multifaceted and speaks in many voices. One can have multiple standpoints. "Subjectivity is the site in which others socially construct one's identity" (p. 491). Poststructuralist thought recognizes that contradictions within the subjective are likely to exist and that changes over time are to be expected.

The poststructuralist perspective is relevant for nursing. It recognizes that power relations with nursing are not fixed (Henneman, 1995). A poststructuralist perspective questions knowledge claims made by groups and how the boundaries of knowledge are maintained and supported. It questions the merit of knowledge that is derived only from scientific, objective reasoning. Foucault in particular addresses the power of the medical 'gaze' in the formation and accumulation of knowledge (Henderson, 1994) and how the "expert knowledge" discourse is shown not to be value-free but often prejudiced and socially constructed (Fox, as cited in Mitchell, 1996). Poststructuralist theory will

question alternative ways of knowing that nurses perceive to be critical to informing nursing practice but it encourages questioning, exploring, and developing knowledge rather than restricting its boundaries.

Although feminism and poststructuralism do not mirror one another, each approach "asks different questions and offers distinctive insights that the other has ignored or missed" (Diamond & Quinby, 1988, p. x). The contributions of feminism and postructuralism can be mutually corrective.

Critical Social Theory

In order to explore the learning experiences of students in an initial clinical course there has to be an acknowledgment of 'the social' as central to any discussion. Individual experiences are located in society and history and are "embedded within a set of social relations which produce both the possibilities and limitations of that experience" (Acker et al., 1983, p. 425). Purkis (1994) contends that the social is integral to the practice of nursing and that nursing work is "accomplished between social actors" (p. 315). By acknowledging the position of the social in the research, not only are data open for analysis but also the researcher's account of the conduct of a research project.

Jurgen Habermas' critical social theory was developed in order to place technical knowledge within a "comprehensive theory of rationality" (Habermas, 1971, as cited in Street, 1992, p. 90). I have found Street's interpretation of Habermas' theory to be helpful in understanding the theory, and her explanation will be used as a basis for this discussion. Habermas identifies three learning domains in his theory: the technical domain, the practical domain, and the emancipatory domain.

In my experience, beginning nursing students place a great deal of importance on technical knowledge which is understandable because there is increasing technology in nursing practice and value is placed on technology by the ruling hegemony. The empirical sciences have provided data to understand technical interests by using the scientific process. There is lesser value placed on invisible work that nurses do. However, Habermas states that technical knowledge needs to be placed in the context of society and culture because many aspects of life are symbolically structured and cannot be represented by instrumental knowledge. Knowledge is shaped within the context of social, historical, and cultural conditions and is determined by specific needs, desires, and interests. Habermas argues that the exclusive objective process of gaining knowledge has led to the abandonment of the reflective process where the subject examines and critiques the relationship between knowledge and human interests.

The second learning domain Habermas describes is the practical domain. According to Habermas, practical knowledge involves interaction and communicative action. That is to say, many times learning involves seeking to understand rather than to find a cause. Habermas argues that practical knowledge is valuable in explaining subjective meaning but fails to "account for the objective context" (p. 91). Habermas describes a third form of knowledge called emancipatory knowledge which recognizes the influence personal history and biography have on a person's self-understanding.

> The emancipatory area is about gaining power over the forces which control and shape our lives even though these forces may

> first be seen as beyond human control. Insight can be gained through critical self-awareness and become emancipatory in the sense that people can come to recognize reasons for their problems and limitations. (Mezirow, as cited in French & Cross, 1992, p. 84)

Learning technical skills and gaining technical knowledge in nursing education has an important place. It helps nursing students anticipate some patient behaviors and gain confidence in the 'doing' of nursing. But there are other forms of knowledge that inform learning that students bring into their courses and clinical practice from their life experiences that are also valuable. It is these informing practices that I want to tease out from the ethnographic data.

In the next section I describe the rationale for incorporating a Goffmanian approach to data collection.

Goffman: The Presentation of Self in Everyday Life

According to Goffman (1959), an individual (or performer) has a variety of motives for trying to sustain a particular impression of the self in front of others. He uses the metaphor of a "performance" which I have found to be helpful in describing the behaviors I observed and discourse I heard coming from the student participants in the study. I will therefore continue to use this metaphor often throughout my thesis. I will describe in more detail the use of the performance concept.

When an individual plays the same part to the same audience on different occasions, a social relationship is likely to arise. The "social front" is "that part of the individual's performance which regularly functions in a general and fixed fashion to define the situation for those who observe the performance" (Goffman, 1959, p. 22). The front consists

of a number of standard parts. First, there is the "setting", which consists of furniture, decor, and physical layout. Second, is the "personal front" that refers to the items that one can identify personally with the performer. For example, clothing, gender, age, race, posture, speech patterns, facial expression, etc.

Goffman (1959) divides the personal front into two components, appearance and manner. Appearance refers to stimuli which indicate a person's social status and the indicators of whether a person is engaging in a social activity, work, serious study and the like. Manner may be taken to refer to "those stimuli which function at the time to warn us of the interaction role the performer will expect to play in the oncoming situation" (p. 24). A person's manner may be expressed as assertive, meek, apologetic, etc. There is expected to be some kind of congruency between the setting, the appearance, and the manner of the actors. In general, the social front is the general and abstract information that is conveyed by the performers. It allows the observer to group people in a broad category so a "different pattern of expectation and responsive treatment" (p. 26) does not have to be maintained for each different performer. This makes it easy for the observer to recall past experiences with this type of performer and to mobilize stereotypical thinking, For example, a patient may have an image of a student nurse that she holds and this conception may influence how the patient responds to the student nurse based on prior experience with students or the stereotypical image of a student nurse.

Interestingly, Goffman (1959) also points out that when an actor takes on a social role (as a student takes on the role of a nurse), usually

she/he finds that a particular front has already been established for her/him. People respond to the presentation of the front that has been established previously even though there may not be a perfect fit between the character of the performance and the general socialized guise in which it appears.

Goffman (1959) writes that individuals tend to infuse activities with signs which highlight facts that otherwise may remain unseen to ensure that the specific activity is obvious to others and will communicate a particular message. For example, nursing students who walk up and down the halls of a nursing unit are trying to look busy in case they are seen by the instructor. This type of activity may lead to the dilemma of "expression versus action" (p. 33) in which an actor may become exhausted from playing a role and actually not perform a desired activity at an expected level because of this fatigue. Goffman notes that this performance "is molded and modified to fit into the understanding and expectations of the society in which it is presented . . . (and) offer[s] their observers an impression that is idealized" (p. 35). He provides six suggestions for a person to project an idealized image of behavior. First, the performer may be profiting from activity concealed from the audience. Second, it is a method of covering errors or mistakes. Third, in those interactions where there is an end-product, the person will tend to only show the finished product thereby hiding the amount of effort (either great or little) it took to produce the product. Fourth, the discrepancy between appearance and overall reality can be concealed. Fifth, if the performer is to embody an ideal standard, other standards will be sacrificed in order to maintain that ideal standard. And last, an image

may be presented to foster the impression that there are ideal motives for acquiring the role which they are performing. There is, in essence, a tendency to conceal activities, facts, and motives which are incongruent with an idealized image.

The description of Goffman's (1959) frontstage behavior of people has been a vehicle for exploring student nurses' backstage realities of learning in an initial clinical course. I believe that it would be misleading to think that all frontstage performances are false or do not reflect clinical learning but the backstage area is the place where the audience cannot intrude and the performers can relax briefly from the performance. The performers have some control over the access of the backstage to prevent the audience from seeing the "vital secrets" of a show (p. 113). Goffman contends that " the line dividing front and back regions is illustrated everywhere in our society" (p. 123). This is apparent in educational settings. Instructors can be represented as the audience and students as the performers. Students present to instructors an image that they have developed or practiced that embodies an ideal standard. It is only when the students move backstage that they can bring to the surface the suppressed facts relating to their situation that perhaps are incongruent with the frontstage performance.

Method

The research method used in this study was an ethnography. In the traditional sense of the word, a method is a technique used to collect data from passive subjects. In the feminist mode of thinking, method becomes both a technique and an interactive process. What I present in this section may appear to be somewhat static as I describe the process

of the method. It was, however, more than just a method; ethnography in this case was both a method and methodology for all the reasons I described when I discussed feminist research principles.

Ethnography is both a process and a product according to Germain (1986). She states, "as a process, ethnography is the traditional research approach to the development of theories of culture", and as a product "ethnography is a factual description and analysis of aspects of the way of life of a particular culture or subculture group" (p. 147). Germain provides an excellent interpretation of the method of ethnography, and her descriptions of the process will be used as a guide in describing ethnographic research.

Ethnography is a holistic perspective of a culture or subculture. Within this culture or subculture, the major research "instrument" is the ethnographer who looks for connections, patterns, themes, or relationships that have meaning for the people in the culture. The ethnographer does not pretend that the study is context free, she/he "recognizes that human behavior is context related and aims to capture that context in rich, particularizing detail" (Germain, 1986, p. 148).

The goal of ethnography is to "discover the cultural knowledge people use to organize their behavior and interpret their experience" (Germain, 1986, p. 149). Ethnography aims at identifying the implicit aspects of a culture, cultural knowledge that may be unexamined and taken for granted by the people being studied, and explicit aspects of a culture. Cultural knowledge is identified by the people in the culture.

Ethnography is a theory-generating method of research rather than a theory-testing method. "Ethnography contributes to descriptive

and explanatory theories of cultural behaviors and meanings" (Germain, 1986, p. 148). Descriptive or explanatory theory is produced by identifying themes in the parts of the culture, the relationship of the parts to each other, and the relationship of the part to the whole cultural scene.

Nursing students are a subculture or the subunit of nursing which, in turn, is intimately related to the world of women. Exploring a portion of the educational experience, such as a clinical course, for study would be considered a microethnography. As a nurse ethnographer I had the advantage of knowing the language of health care, being comfortable in health care environments, and being able to capture the data that might have been missed by nonnurse ethnographers. In addition to these advantages, I have also belonged (and belong now) to the subculture of nursing students and drew on this commonality to build relationships with the participants in the research.

Gaining Access

Gaining access to a group or subculture involves more than being physically present in an environment, it involves gaining access to the realities of student nurse's lives. I wanted to capture both the frontstage realities of learning and the backstage realities through interviews and observation.

The emphasis of the study is on backstage explorations of learning experiences but it would be naive to think that front and back are dichotomous. Gaining access to the backstage realities of student learning is a difficult process. Being interviewed and observed, even in a non-threatening environment, puts a person on stage. One of the

potential difficulties noted by Field (1989) is the effect of a third party on the observed interaction. "Being observed often carries with the threat of evaluation or judgment of their nursing care" (p. 84). Lipson (1991) additionally notes that:

> The data elicited through ethnographic methods are influenced by the informant's evaluation of the researcher. Informants make judgments on many levels about what is safe or acceptable to tell researchers. At first, they may judge the researcher in terms of such external characteristics as cultural background, age, gender and social status, obvious personality features, and perhaps professional background. As relationships deepen, the personality and culture of the researcher have more impact than 'externally obvious' characteristics. (p. 65)

To attempt to minimize the need to "perform" for me, I was present in the school environment every day and within a few days acclimatization to my presence seemed to occur. Although I had a significant interest in gaining access to the insider information that the participants held, I believe that it was an advantage that I was also a student. As a student I was able to empathize with student frustrations and relate to their experiences. Although I am a nursing educator professionally, I have never taught in a baccalaureate program nor was I familiar with the curriculum in this particular nursing program, ensuring a modicum of cultural ignorance about the environment. As well, I reinforced my non-evaluative role in this study to the students by

explaining that the purpose of the study was not to measure how well they learned but to have them share their learning experiences with me.

The Participant-Observer Role

Because data for ethnography are collected by interviewing participants, observing actions and behaviors, and collecting archival materials (Germain, 1993), the ethnographer must establish rapport with the participants in order for the ethnography to be successful. Spradley (1979) describes rapport as "a basic sense of trust . . . that allows for the free flow of information" (p. 18). It takes effort to develop rapport with a number of students especially within a very short time frame. The first step toward establishing good rapport with the participants meant that I had to consciously try to 'fit in' with the group.

As an observer-as-participant, I actively participated in the students' experiences external to formal teaching settings in a 'low-key' manner yet attempted to blend in with the group in such a manner that I was not perceived as 'the researcher'. Junker (as cited in Germain, 1986) describes an observer-as-participant as a researcher who is publicly known at the outset and interacts with the participants - no attempt is made to disguise the researcher or observe the participants without being in close physical proximity to the participants. To remain "low-key" throughout the ethnographic research I dressed in a fashion similar to them, came to school at the same time as the students, and attended coffee breaks and lunch breaks with the students.

Spradley (1979) describes a successful rapport process as usually proceeding through four stages: apprehension, exploration, cooperation, and participation. Although Spradley refers to these stages in relation to

ethnographic interviews, they also appear to be applicable to the general rapport process that developed with the participants and myself.

The first stage of the rapport process, apprehension, was evident when I introduced myself and explained the method and purpose of the research. I sensed apprehension or hesitance in agreeing to participate in the study from the group. The students who agreed to participate were unknown to me and I to them. As Spradley (1979) notes, initially, the informant does not know what to expect, and does not really understand the purposes and the motives of the researcher. Five students initially agreed to participate in the study but as the students became used to my presence and the nature of the research became clearer to them, the total number of participants increased to ten. The additional five student participants either requested to participate in the study or were requested by me to participate when they related information that was pertinent to the study. These five students were not considered key informants. One student described her hesitancy to participate as such:

> Although you told us about the research you're doing, I didn't really understand it until after you'd been here awhile. I don't mind if you ask me questions if it will help you out.

As well, Spradley suggests that informants in an ethnographic study may fear that they will not meet the expectations of the researcher. I found that many students prefaced the beginning of their interviews with "I'm not sure if what I have to say is important" or "I don't know if what I have to say is what you're looking for". To reduce the student's apprehension about the interview and data collection processes I talked to them about my interest in hearing what they had to say, used descriptive questions,

attentively listened and responded in a non-judgmental manner to their comments. As Polit and Hungler (1995) note, interviewing is a method of data collection that depends on the honesty of the informants and the researcher has to trust the information given. Therefore, the more trusting the relationship between the researcher and the informant, the more comfortable the informants will feel to share their thoughts and feelings.

The second stage of the rapport process is exploration. "Exploration is the natural process of becoming familiar with this new landscape" (Spradley, 1979, p. 80). The exploration phase was the time when the students and I discovered what each other were like. I delayed conducting formal interviews and focused on getting to know the students during coffee breaks and lunch breaks. I asked them informal questions about their lives, their experiences in the nursing program to date, and their thoughts about the clinical course they were presently enrolled in. I used this time to reiterate the purpose of the ethnographic research and the value of their input.

The third stage of the rapport process is cooperation. Spradley (1979) describes this stage as different from participation. He describes this stage as "more complete cooperation based on mutual trust" (p. 82). In this ethnography, students indicated their growing trust in me in a number of ways. During the more formal interview session, occasionally students would look around to see if the doors were closed in the interview area before responding to the question indicating that they were willing to share the information but did not want anyone to identify them as the source. Eventually, the students would correct me if I

misinterpreted their comments or would look at some of my field notes and indicate something I missed. Every time this happened I sensed their growing trust in disclosing information.

The last stage in the rapport process is participation (Spradley, 1979). Toward the end of the ethnography students began bringing new information to me about their culture and were beginning to analyze culturally significant terms. For example, during coffee break one day this interchange occurred:

> Erna: (In response to someone saying they had to get their client up on the commode). Isn't there another name for commode?
> Researcher: Ya, it's a bureau like the thing that the wash basin and pitcher used to go on - an antique.
> Erna: My parents have their TV on a commode, I get a whole different mental picture when someone says the word 'commode' now.
> (General laughter from the group of students present)

Reflexivity in the Fieldwork

It is acknowledged that the ethnographer is the primary research "instrument" in ethnographic research (Germain, 1993). However, it is essential to recognize the ways in which self, in both one's experiences and assumptions, affects research processes and outcomes (Williams, 1995). Throughout the ethnographic fieldwork, questions would be directed toward me. Students expected me, at times, to answer their questions. Because the purpose of this study is to explore the experiences of clinical learning with novice nursing students and because a resource person such as myself would not normally be available to answer their questions, I had to consider their requests carefully.

My first consideration was of Anderson's (1991) suggestion that "while strategies may be sought to evade dealing with direct requests by informants, one could interpret such requests as germane to the research, and see them as informing us about the social production of knowledge" (p. 117). If I refused to answer any questions it may have reinforced the notion that knowledge was something to be hoarded and not shared freely. Conversely, providing answers to every question, regardless of the content, may not facilitate a non-hierarchical relationship between myself and the participants. Freire (1993) criticizes those who perceive knowledge to be like "a gift bestowed by those who consider themselves knowledgeable upon those whom they consider to know nothing" (p. 53). Subsequently, I dealt with this dilemma by briefly answering any procedural questions or questions that requested my opinion about a topic. When questions arose that involved specific knowledge of, for example, the charting system used in the hospital, I made no attempt to guess at the answers and encouraged the students to ask someone else. I believed that to 'fit in' with the group, I could not pretend to be culturally ignorant about topics that the students would recognize as being essential to my role as a nurse yet, at the same time, I recognized that my presence in the student nurse subculture subtly changed the learning environment as reflected in this statement:

> I missed seeing you in your usual spot yesterday [referring to the area where I sat adjacent to the nurses' station]. I know that you're not here to help but just seeing you there everyday makes me feel more secure (Casey).

Research Questions

Ethnographic research learns about a culture by asking questions and seeking clarification of observations. There is a degree of flexibility with ethnographic research that allows revision of research questions as "new discoveries lead to new directions for cultural understanding" (Germain, 1986, p. 149). For example, MacKenzie (1992) found that asking students outright about what helped them learn was not very useful because students had difficulty describing how they learn. It was through the students' descriptions of what they had done that helped them identify instances of learning. Therefore, the initial questions that I posed for this research were:

1. What are the learning experiences of novice nursing students in an initial clinical course?
2. How do students describe these learning experiences?

Although there were other aims for the research process as reflected in the guiding principles of the research, the overall questions remained the same throughout the research.

Data Collection

Demographic Information

Demographic data (Appendix A) were collected on the five key informants. The key informants were all single, white females. Their ages ranged from 19 to 29 years of age. One participant had a child. Although formal data were not collected on their cultural backgrounds, through conversations with them I established that three of the five women were from a francophone background and two from an anglophone background. All but one of the participants were from the local area.

Prior to entering the baccalaureate nursing program, all the participants had some form of work experience. Most of their jobs were unrelated to nursing. Only one participant had experience working in the health care field as a personal care worker. The educational backgrounds of the students were varied although all had completed grade 12. Two of the women had taken post-secondary courses related to the health care field. Three of the participants had anywhere from one to three years of education at a university level (excluding the present year). Only one participant came directly into the baccalaureate program from high school.

These demographic data do not do justice to the rich and varied backgrounds of the participants' lives but only serve to remind us that the participants in any study are situated in the context of their histories, cultures, race, etc. As students, they can on longer be perceived to be 'blank slates' that need to be filled up by well-intentioned educators.

Field Notes

Extensive field notes were recorded throughout the ethnography. I incorporated the "language identification principle" advocated by Spradley (1979). This principle recommends that field notes be recorded as soon as possible after observations or discussions and dialogue be recorded as close to verbatim as possible. Where unobtrusive, I took notes in a small book. If not possible, I recorded those occurrences that I wanted to remember immediately afterwards. I organized my field notes into condensed accounts (observations and dialogue that are quickly

recorded) and expanded accounts (expanded versions of the condensed accounts).

I made observations of student behaviors and discussion during coffee and lunch breaks, during practice time in the clinical laboratory, and during the times I was invited into the classroom by the instructor specifically. It was not my intention to make student-instructor observations but to refuse specific invitations would not have been sensitive to the spontaneity of the situation and would have highlighted the differences between the researcher and the participants. In the two institutions where the students had their clinical experiences, I sat in a small area adjacent to the nurses' station where the students kept their reference material and where they came to sit when they were not caring for patients or otherwise occupied. During these times I would talk to them about their learning experiences and take notes. Students were given the opportunity to read the field notes at any time and suggest changes or add more information. Although field notes can only represent a fraction of the experiences observed, they intimately communicate the events that occurred during the ethnography that interviews alone cannot communicate.

Interviews

In anticipation of ethnographic interviews, a series of questions that were used as interview probes were generated (Appendix B). The probes were incorporated within the semi-structured interviews with the key informants. Eight taped interviews were conducted throughout the ethnography each lasting from 30-60 minutes. Two of the interviews were conducted with two key informants present and six consisted of just one

key informant and myself. The interviews usually related to the events that had transpired in the course to that date.

When the occasion did arise for a formal interview I used Spradley's (1979) three interview principles for rapport-building. The principles encourage repeated explanations, restating what the informants said, and asking for use of a word or statement in the context of how it was used by the key informant.

At the beginning of each interview I would explain the purpose of the study and the importance of hearing their voice in the data. I would also reflect their statements to encourage further explanation and ask for use of culturally specific words. Cultural meaning emerges from understanding how people use everyday language (Spradley, 1979). For example, the term "hands-on" was frequently used by students to describe nursing care. With the students, I would restate, then ask how the phrase would be used in context. In one instance I said, "You've used the term 'hands-on'. Would you consider when you talk to a patient 'hands-on'?" Exploration of culturally significant terms is essential to ensure that the informant's interpretation of the term is clear. It would be easy to assume the definition of a term incorrectly based on personal use of the term. As the interviews progressed, based on my observations and initial analysis of the data, the questions reflected what I had observed and focused on seeking clarification of these observations from the participants.

Artifacts

Permission for reviewing additional data sources was obtained from the participants (Appendix C). The key informants gave me

permission to view the videotapes of their therapeutic communication sessions, clinical journals, and health history assignments. I also obtained permission for copies of the other five participant's clinical journals. Artifacts such as course schedules, course outlines, marking guidelines, required readings, and class handouts were obtained from instructors who were not only supportive of my presence but eager to have research conducted in their school.

Journal

In addition to the three data collection methods noted, I kept a reflexive journal record of my experiences, fears, mistakes, ideas, and confusions that arose during the fieldwork. I continued to write a journal throughout the research experience to meet both feminist and ethnographic research principles.

Trustworthiness of the Data

Ethnographic research calls for the collection of a thick description of the culture. The focus of the data analysis was on understanding of the participants in the study and the observation of their activities in their everyday lives (Hammersley & Atkinson, 1989). MacKenzie's (1994) criteria for evaluating ethnographic research was used as guide for establishing trustworthiness of the data.

As noted in the sections above, key informants, ethnographic interviews, multiple data collection methods, fieldwork, and a reflective journal were used in the study as required by MacKenzie (1994) as sources of trustworthiness. The data were analyzed using thematic analysis. Evidence from interviews, observations, field notes, and artifacts were reduced into conceptual categories called themes. The

triangulated data from the study were coded into categories by three independent coders and re-coded into three themes based on the results. Careful consideration was given to the repetition of particular phrases throughout the data and its occurrence across a variety of settings. The title of each theme was taken verbatim from the transcripts. Hammersley and Atkinson (1989) refer to this type of textual arrangement as "member's categories" or "folk categories" and are "situated in the vocabulary of the culture" (p. 225). General descriptions of these themes were shared with the key informants from the study. There was consensus from the group that the three themes were representative of their lived experiences. Next, the themes were divided into sub-themes or more analytic categories that were developed from the data. Extended use of informant accounts were used throughout the analysis to make visible the words of the key informants. As a final technique to ensure trustworthiness of the data, the analysis was openly shared with the key informants for their critique. Changes were made to the analysis based on this feedback.

Ethical Considerations

Permission to conduct this study was obtained though the Ethics Committee of Graduate Studies at Dalhousie University. A letter describing the intended research was sent to the Site Administrator at the School of Nursing (Appendix D). Permission for the research to take place at the School of Nursing and the associated regional hospital was obtained. A letter of introduction was given to the first year baccalaureate nursing student representative and the representative circulated copies to the remainder of the class (Appendix E). Each

participant signed a consent form acknowledging their agreement to participate in the study and to have the interviews recorded and artifacts copied (Appendix C). The participants were informed that they could withdraw from the study at any time. The participants were reassured that confidentiality and anonymity would be maintained in transcriptions and in written or public presentations of the research. All student names in the study are assumed. The completed demographic data, interview tapes, transcripts, and field notes were held confidential in a locked filing cabinet when not in use. Any data of a sensitive nature about an instructor was not recorded.

CHAPTER III

A Critical Review of Nursing Education History

> To realize the extent of nursing's progress and to assure its continued growth, it is important for nursing historians to document the nature of past constraints to nursing education and professionalism, to assess the profession against the background of society in general, and to be alert to potential similar problems in the future. (Matejski, 1981, p. 29)

The historical process of educating nursing students is inextricably linked to the socially constructed reality of present-day nursing and nursing education. To understand the realities of nursing education today, I will briefly review the development of nursing education historically. Throughout this review I will examine nursing education development within social, gender, political, economic, and class contexts.

The first nursing schools in Canada were established in the late 1800's. The St. Catherine's Training School was established in 1874 and was said to have incorporated Florence Nightingale's ideas about the training of nurses (Kerr, 1990a). Nightingale believed that women should be educated and have the same rights to education as men (Barritt, 1973). She advocated that by educating women for the nursing profession, and compensating them well for their work, that intelligent independent women would be attracted to its ranks and graduates would then change nursing practices throughout the world (Barritt, 1973). However, in Canada, as in the rest of the Western world, training "more often emphasized development of personal qualities such as altruism, womanly devotion, and dedication than the traditional educational

objectives such as acquisition of knowledge or the ability to think and reason" (Baumgart & Larsen, 1988, p. 315).

One of the reasons why the ideals that Nightingale advocated were not implemented was because of the societal pressures exerted on women at this period in history. Healey (as cited in Kerr, 1991) notes that constraints were imposed on women enrolling in nursing because it was considered an undesirable vocation for a refined lady. Matejski (1981) identifies that an external factor, such as social class status of potential students, influenced the appeal a profession had for these students. In the late 1800's, it was expected that an upper-class woman would marry and take her place in society (Barritt, 1973). Women were generally deterred from seeking higher education. According to Baumgart and Kirkwood (1990), the arguments against education included women's intellectual inferiority and their obligation to maternal and domestic responsibilities. However, the popularity of nursing as a career provided certain groups of women the opportunity to improve their financial and social status. Most nursing students in Canada came from working-class or lower-middle-class backgrounds and were not required to have high academic standing prior to admission (Coburn, 1988). Because the public image of a nurse as nurturer, moral guardian, and efficient manager did not lend itself to calls for academic training, the movement of nursing education into the "academic milieu" was slow (Lynaugh, 1980, p. 269) and met numerous barriers. The "natural division" of labor between men and women of the times was reinforced by nursing's nurturing and caring functions that were perceived to be

extensions of the role of women in the home (Baumgart & Kirkwood, 1990).

> Because virtually all nurses, trained and untrained, were women, the profession was seen by society (and saw itself) as an expression of womanhood. The nineteenth century, refined, middle-class ideology of separate social spheres for men and women helped confine nursing, as a woman's profession, to a lower economic and educational standard. (Lynaugh, 1980, p. 267)

A second reason for the failure of Nightingale's ideals to be realized may have been due, in part, to the inability of schools of nursing to remain financially independent of hospitals (Matejski, 1981). Florence Nightingale founded the first school of nursing in conjunction with St. Thomas' Hospital in London in 1860 using independent funding (Barritt, 1973). In Canada, schools of nursing were compelled to become "completely dependent on the financial stability of the hospital with which they were associated, and their policies were dictated by a board of trustees" (Kerr, 1991, p. 233). Most hospital training schools did not have educational objectives, but rather the objective was to supply workers to provide care for the hospitalized sick (Christy, 1980). Students were forced to carry out most of the work in hospitals and received minimal formal education - some schools of nursing did not have even one full-time instructor (Weir, 1932).

The proliferation of nursing schools coincided with the increasing numbers of hospitals in Canada. Student nurses provided a critical source of cheap labor to poorly financed, labor-intensive institutions

(Lynaugh, 1980). Maintaining schools of nursing within an institution often determined whether hospital beds were available or closed to the public which had financial ramifications for the institution (Coburn, 1988; Lynaugh, 1990). Rapid and uncontrolled growth of nursing schools that were funded and administrated by hospitals meant that nursing education was clearly out of the hands of the nursing profession (Garling, 1985).

Another external pressure that influenced the development of nursing education in the late 1800's was interest of the medical profession in controlling the commodity of nursing (Lovell, 1981). The medical profession became aware that nurses had the potential to be as important to the health of society as physicians (Haselting & Yaw, as cited in Lovell, 1981) and wanted to direct nursing education toward their own interests before nursing education leaders reformed nursing education to benefit nurses. Physicians became involved in deciding about curriculum content in the guise of being the "expert" and thus were able to determine what knowledge would be useful for nurses (Street, 1992). As a result of the involvement in curriculum decisions, physicians kept the focus of nursing on supporting their needs (Richard, 1996). Thus, nursing education curricula resembled the medical, male-oriented professional ideology that equated scientific process with being professional (Dickson, 1993).

Within nursing education itself, there were developmental roadblocks. Nursing leadership accepted the "cultural authority of science and the leadership role of medicine in applying science to health" (Lynaugh, 1980). Roberts (1983) identifies the internalization of

dominant group values by nursing leaders as an example of how nursing is oppressed. By believing in the norms and values of the physicians of the time, nursing educators perpetuated this oppression. "Nursing leaders promoted the sexual stereotype of women's unique contribution to health services as complementary to medicine" (Baumgart & Kirkwood, 1990, p. 511). It must be remembered that the nurse educator and nursing administrator were often one and the same person. In Canada, the Superintendent of Nursing was, in 91% of the time, the principal of the training school and taught what little classroom instruction there was available (Weir, 1932). These same nurses had a multitude of roles to fill and answered to a number of powerful people. By internalizing the characteristics of the dominant groups of the times - physicians and hospital administrators - nursing educators would also be resistant to any suggestion to change nursing education practices (Richard, 1996).

In summary, at the turn of the century, educational programs for nursing were poorly developed. The foundations that supported the ideals of Nightingale schools of nursing were eroded in Canada by societal pressures on women to not enter nursing, the financial dependence of schools on hospitals, resistance by physicians to the autonomy of nursing, and the conflicts between Canadian nursing leadership and Nightingale's ideals.

The Effects of the Flexner, Goldmark, and Weir Reports on Nursing Education

Until the late 1800's both nursing and medicine were based on the apprenticeship model of education (Matejski, 1981). This type of educational model meant that nurses and physicians learned to do by

doing. However, physicians were educated by associating with a practicing physician but nursing students primarily learned from each other (Dickson, 1993). Neither nurses nor physicians appeared to be receiving adequate educational preparation for their professional responsibilities. Studies of medical and nursing education were initiated in the early part of the twentieth century that recommended the need for higher educational standards. The Flexner Report of 1910, the Goldmark Report of 1923, and Weir Report of 1932 have respectively affected the development of nursing education in Canada.

Throughout the nineteenth century, medical proprietary schools were open to just about anyone who could pay the required fees, and the MD degree was in itself a license to practice (Kunitz, 1974). Physicians came from every class of people and only foreign education (particularly if completed in Germany) distinguished the elite from the "rank and file" of the profession (Kunitz, 1974). Germany provided a model for university education that stimulated the American Medical Association's interest in educational standards (Matejski, 1981). "It was clearly recognized that improved standards in medical education would narrow the social spectrum from which physicians had previously come" (Markowitz & Rosner, as cited in Kunitz, 1974, p. 21).

The aforementioned potential results of improved standards in medicine seemed to be the impetus for the Flexner Report of 1910. The Flexner Report described and 18-month study of medical education in the United States and Canada (Flexner, 1994). The results from the report identified that:

> medical schools had very low educational standards for admission and were inconsistent in applying what they had, possessed inadequate clinical and laboratory facilities, and produced too many and too poorly trained doctors. . . . His [Flexner's] recommendation was to close down the inferior schools and strengthen the better ones. He [Flexner] also urged placing all medical schools under university control, increasing pre-admission educational requirements, lengthening the curriculum, and improving facilities. (Garling, 1985, p. 26)

This 1910 report provided a list of names of medical schools that did not meet the established standards and this list was published and distributed extensively using graphic descriptions of the appalling state of medical schools (Garling, 1985). As a result of Flexner's study, many schools closed, millions of dollars were channeled into a few medical schools, fewer and better educated doctors emerged, and the apprenticeship program passed into history (Garling, 1985). As a result of this medical reform, the medical profession became one almost exclusively for white, upper-class men (Dickson, 1993). Physicians had established themselves in a position of power that suppressed any opposition to their authority. Student nurses were taught complete subordination to physicians, administrators, and nurse superiors (Coburn, 1988; Valentine, 1996).

In 1923, the Committee for the Study of Nursing Education in the United States was initiated because of the need for improvement in the education of public health nursing but quickly increased its scope to

study nursing education in general (Bullough & Bullough, 1981; Committee on the Study of Nursing Education, 1984; Kalish & Kalish, 1983). Josephine Goldmark was placed in charge of the survey research and 23 representative schools of nursing (that remained anonymous) were selected for intensive study. The Goldmark Report was published in the period following World War I (Committee for the Study of Nursing Education, 1984). Many women who demonstrated their ability to assume responsibilities in the work force remained gainfully employed. The work ethic was strong and success through hard work was encouraged. Women who worked in industry came to view nursing as a suitable career for their daughters, a career that could ensure their financial independence and improve their social status (Matejski, 1981).

The Goldmark Report made the following recommendations for nursing education; reducing the length of the course, reducing service time and increasing time for formal education, eliminating repetitious tasks, increasing admission standards, replacing student staff in hospitals with graduate nursing staff, and eliminating schools of nursing from specialized or small hospitals (Matejski, 1981). Although nursing leaders supported these recommendations, there was little change within nursing education (Richard, 1996).

There are a number of possible reasons for the lack of change in nursing education after the Goldmark report. First, the report did not publish the names of the schools of nursing that did not meet appropriate educational standards, unlike the Flexner report. This softer approach to chastising the schools of nursing and the hospitals that administered them seems to have undermined the seriousness of the

report. The Flexner report described in graphic detail the state of the "so called" medical schools, but the Goldmark report summarized the deficiencies into a list that applied to all of the schools of nursing studied (Matejski, 1981). The fact that only 23 of 1,800 hospital schools of nursing were studied may have also diluted the impact of the study.

Second, in comparison to the 1,800 schools of nursing, there were only 133 medical schools in existence at the time of the Flexner report. The logistics of effecting change in so many schools of nursing, compared to relatively few medical schools, may have been a deterrent to any change at all.

Third, recommendations for sweeping changes to schools of nursing had serious financial ramifications for hospitals. Hospitals, at this time, were pressured by advances in new medical science to increase their technology to draw physicians (and their patients) to their facilities in order to ensure survival of the hospital (Garling, 1985). The threat of having to hire graduate nurses (instead of drawing on student labor) at the same time when capital costs were increasing, spelled economic hardship for a hospital. The support for educational reforms in nursing was probably not upheld by either the institutions or the public if they were perceived to be contributing to reduced hospital services (Richard, 1996).

Fourth, the foundation follow-up money for nursing education was only $2 million compared to the $154 million medical education received by 1938 (Garling, 1985). Two million dollars does not go very far when distributed among 1,800 schools of nursing, so the money was channeled into developing three university schools of nursing. However,

these three schools were perceived as "different" from hospital-based schools of nursing (Garling, 1985). The administrators of hospital schools of nursing may have perceived the use of foundation money for university schools of nursing as elitist as there is no evidence that the university programs were aimed at educating graduate nurses to a baccalaureate level (Richard, 1996). The existence of only three university schools of nursing also made higher education geographically and economically inaccessible to most women considering entering nursing.

The failure of the Goldmark report to change the foundation of nursing education in the United States from an apprenticeship model, to one based on educational principles, may have left unheard the call for improved standards in nursing education in Canada. It was not until 1932 that the Weir report was published as the Survey of Nursing Education in Canada, nine years after the Goldmark report.

The Weir report was prompted by the Canadian Nurses' Association (CNA) and the Canadian Medical Association (CMA). According to Baumgart and Kirkwood (1990), the CNA's intent for the survey was to achieve educational reform in schools of nursing in Canada by developing nursing research and nursing scholarship. The CMA's involvement in the survey was primarily an attempt to restrict nurses from achieving this educational reform.

In the report, Weir (1932) extolled the virtues of a liberal education for nurses and harshly criticized admission standards and the quality of information given to students once admitted, but recommended leaving schools of nursing in close association with the administrative powers of hospitals. Weir stated:

> It will be admitted that it is economically unsound to spend more money in training nurses at university schools of nursing than would be spent in giving them an equally good training at schools connected with hospitals. The mere prestige of university training, apart from its alleged superior quality, would not, in itself, appear sufficient to warrant the additional expenditure, if any, involved in transferring the education of nurses to university auspices . . . . In a word, to pay a higher price for the same quality of service that can be obtained at a lower price is little better than extravagance. (p. 391)

It appeared that Weir was suspicious of the control that hospitals had over nursing education in 1932, but was not willing to promote university education as a sole means of nursing education. Weir (1932) recommended that the funding for nursing education be integrated into the general provincial education system but it was not clear if this meant that schools of nursing should be physically and administratively removed from the hospital setting. At this time nurse educators in hospital schools of nursing were employees of the hospital and, as employees, did not have the freedom to exercise their academic rights because of the threat of dismissal that the hospitals could hold over their heads. Curricular change within schools of nursing would be difficult to implement in such an environment.

The financial implications of educating nursing students in a university setting appeared to be significantly important in the Weir document. The Flexner report showed no concern about the financial ramifications of medical schools moving into university settings. It could

be argued that Weir was concerned about the accessibility of nursing education for the greatest number of students but it could also be argued that university education may have provided status to the nursing profession that was undesired by the power groups within the hospitals and universities (Richard, 1996). It must be remembered that Weir, no matter how progressive his ideas were, was a product of the social influences of his times. During the survey, Weir talked to many health care groups with, undoubtedly, agendas of their own for the future of nursing education. It can only be speculated how these groups influenced Weir's recommendations. Physicians, as an example, valued characteristics such as "obedience, manners, and femininity" in nursing students (Murphy, as cited in Valentine, 1996). By keeping tight controls on nursing education, Valentine (1996) suggests that physicians were better able to keep nurses in a subordinate position. Similarly, university education for women at this time was only perceived to be a method of preparing women for their eventual role as wives and mothers (Baumgart & Kirkwood, 1990).

In summary. the Flexner report on medical education was instrumental in claiming a license from society for autonomous professional status. The Goldmark and Weir reports were much less successful in changing the status of professional nursing in North America. The process for disseminating the results of the nursing reports, the resistance of physicians and hospital administrators to change, the possible lack of support for change by the public, limited financial support for reforms, and social bias against higher education

for women may have all contributed to the failure of the Goldmark and Weir reports to improve nursing education.

Educational Streams

The debate over basic educational preparation for nurses has been argued throughout the twentieth century. By developing two separate streams to attain basic entry level preparation within nursing to practice, internal discord had been precipitated. The movement toward university education for nursing began to make a distinction between the hospital-trained nurse and the university educated nurse creating tensions that continue to exist today (Dickson, 1993).

The curriculum of the Nightingale Training School may have been detrimental to the development of a unified approach to nursing education preparation. Barritt (1973) noted that the basic purpose of the curriculum, which was also implemented in Canada, was to prepare two levels of nursing practitioners. The special probationers were middle-and upper-class ladies who were trained for future teaching and administrative positions, and the ordinary probationers were economically poor ladies who were to serve as ward nurses or private nurses. Although this latter training separated nurses based on social status, there has developed a similar split between diploma prepared nurses and those with a BScN.

University Nursing Education

University based nursing education in Canada became available in 1919 at the University of British Columbia after two previous attempts to establish university education for nursing failed in 1906 and 1913

(Baumgart & Kirkwood, 1990). However, nursing education was not welcomed into the university setting as much as just tolerated.

> As an academic discipline, nursing was viewed with skepticism and suspicion in universities staffed almost entirely by men. Universities were reluctant to admit nursing, and demonstrated their reticence by failing to provide the financial support necessary for educationally sound programs. The terms under which the first Canadian university department of nursing was established . . . was a classic illustration of the current attitude. The Board of Governors of the university approved a department of nursing solely on the understanding that no expense would be accrued by the university. (Richardson, 1994, p. 74)

The baccalaureate nursing degree at the University of British Columbia was based on a non-integrated model. Arts and science courses were offered at the university in year one and year five and the three intervening years were spent as a hospital trainee (Kerr, 1988b; Richardson, 1994). There appeared to be no recourse for graduate nurses to return for a degree in nursing. In 1920, though, the Canadian Red Cross Society provided funds for post-basic instruction in public health nursing (Kerr, 1991a). These certificate programs proliferated much more than did degree programs, and came to include supervision and teaching (Richardson, 1994). It was not until 1942 that the first four-year integrated nursing program was begun at the University of Toronto and thus university authority and responsibility for nursing education was initiated (Thomas, Arsineault, Bouchard, Coté, & Stanton, 1992).

As university nursing programs became established, there was an increasing demand for nurse educators and researchers to become academically qualified to work in university institutions. Dickson (1993) argues that the process of educating nurses at a doctorate level fostered the scientific ideal of objective and value-free empirical evidence as the only way to conceptualize knowledge. She states:

> The adherence of early nursing leaders to the socially successful, available, medical, male-oriented professional ideology has left its imprint on nursing and nursing education. The assumptions at the base of the nurse leaders' imitative behavior of physicians' professional ideology equated being professional, in part, with receiving university degrees and being scientific. (p. 81)

Universities began offering a post-basic degree in nursing as of 1945, which represented only 0.62% of total nursing enrollment. By 1961, the percentage of post-basic students had only increased to 1.03% of total nursing enrollment (Royal Commission on Health Services, 1964). There appeared to be no concerted effort by nurse educators to facilitate nurses enrolling in degree programs. Students who entered a basic baccalaureate program had, even as of 1980, marriage as a major variable when considering full-time commitment to a professional career in nursing (Young, 1984). If only early university educators had promoted education for nurses who were already committed to nursing by, for example, accepting the certificate courses as appropriate for BScN credits, the percentage of baccalaureate prepared nurses in Canada may be significantly different today.

In addition to the previously identified limitations for nurses to attain a baccalaureate degree, promotion of nursing education could have been better fostered by members of the Provisional Council of University Schools and Departments of Nursing, the forerunner of the Canadian Association of University Schools of Nursing (CAUSN). The creation of the Provisional Council of University Schools and Departments of Nursing in 1942 was, according to Richardson (1994), a reactionist association developed in response to the Canadian Nurses Association's (CNA) interest in university nursing education standards. The university representatives declined to organize under the auspices of the CNA and made a motion that established the council as "provisional" to circumvent overt antagonism toward the CNA. As a group, these educators could have coordinated university nursing education activities, or supported college-university collaboration, but as Richardson concludes from reviewing the minutes of the Provisional Council meetings:

> Provisional Council of University Schools and Departments of nursing was a(n) . . . association that reflected the uncoordinated nature of university nursing education and the inability of nurse academics to put aside parochial differences and act in concert to influence public policy. (p. 84)

Diploma Nursing Education

Diploma schools of nursing remained within hospital settings and followed the apprenticeship model of education in the early decades of the twentieth century despite reports recommending the movement of

nursing education into vocational or university settings. In 1948, Red Cross funding enabled the establishment of a demonstration school in Windsor, Ontario that would determine if it was feasible to prepare a nurse in less than three years (Kerr, 1991b). Although the study indicated that educational preparation for nurses was possible in two years, the movement of schools of nursing out of hospitals and into community colleges was slow.

In 1960, the CNA, concerned about the quality of instruction in schools of nursing, instituted a pilot project under the direction of Executive Director Helen Mussallem to determine whether schools were ready for a national accreditation program (Kerr, 1991b). The recommendations made from the study were that a re-examination and study of the whole field of nursing education be undertaken, that a school improvement program be initiated to assist schools in upgrading their educational programs, that a program be established for evaluating the quality of nursing service in the areas where students in schools of nursing receive their clinical experience, and that a program of accreditation for schools of nursing be developed by the Canadian Nurses Association (Mussallem, 1960).

As a result of the pilot project, Mussallem recommended that the focus of the CNA should be on a school improvement program rather than accreditation (Kerr, 1991b). Although there were apparently scandalous conditions very little change actually occurred (M. J. Horrocks, personal communication, April 30, 1996).

Curricula gradually changed in Canadian diploma schools of nursing to include foundation courses in basic sciences. The Hall

Commission Report of 1964 also added impetus to the movement of nursing education into the general education system by recommending; the establishment of a nursing education committee in each province, separate nursing service and school of nursing budgets, the elimination of student service to hospitals, and collaboration with colleges (Royal Commission on Health Services, 1964). In 1964, the first diploma nursing education program at a post-secondary institution in Canada was initiated in Ontario at Ryerson (Rovers & Bajnok, 1988). The move was followed by several other provinces (in whole or in part) which eventually led to the acceptance of nursing education in a variety of settings.

Educators and administrators in schools of nursing undoubtedly felt pressure from hospitals and the community to produce a supply of nurses (Richard, 1996). By eliminating the services of student nurses in hospitals, there would be a demand for registered nurses. The concept of university preparation for all nurses was probably not considered due to these demands. In addition, the Royal Commission reinforced the need to prepare nurse in two streams - diploma and degree-with no recommendations for a unified basic education for nurses.

Despite the changes in diploma education, there appeared to be little communication between university, college, and hospital schools of nursing to establish unified goals for nursing education until serious discussions began regarding baccalaureate education as entry to practice for nurses. Promotion of nursing education was not supported by physicians, universities, hospital administrators, or many nursing leaders. Only reports of the appalling condition of nursing education in

Canada started any change in education methods, and at that, change came very slowly.

Historically, the leadership and goals of nursing education did not seem to be clearly defined. Roberts (1983) argues that nursing did not provide leadership for change because "nursing leaders have represented an elite and marginal group who have been promoted because of their allegiance to maintenance of the status quo" (p. 28). By controlling the environment in which nurses are educated, dominant groups ensure that their values and beliefs are maintained. Nurses have been controlled by groups outside themselves who are perceived to have greater prestige, power, and status. Recognition of the existence of group oppression by nursing leaders is necessary before change within the system can be fostered.

The lack of internal motivation in nursing leadership for change and the external pressure to maintain the status quo both contributed to the divisive nature within nursing. Multiple educational streams to attain entry to practice may have been a practical compromise to produce nurses to meet the perceived needs of clients but it initiated a split within nursing that still exists today.

Entry to Practice Issues

During the 1960s and 1970s nursing education rapidly transformed. Diploma programs began to offer courses which reflected the increasing "scientific foundation of nursing" (Rovers & Bajnok, 1988, p. 326). Educators embraced the values, methods, and procedures of the empirical process found in most universities (Dickson, 1993). Graduate education in nursing became available in Canada and the qualifications

of nurse educators improved. During these transformative times, the most hotly-debated contemporary issue in the nursing profession surfaced - the baccalaureate degree as the minimum educational qualification for entry to the practice of nursing.

It is interesting to note that the motivation for the entry to practice issue originated, not from within nursing, but as a result of the findings from the 1975 Alberta Government Task Force on Nursing Education (Kerr, 1988a). Although the Alberta government denounced the results of the study stating that they did not agree with making the baccalaureate degree a mandatory requirement for practice, the Alberta Association of Registered Nurses (AARN) responded to the Task Force results by endorsing baccalaureate preparation for entry to practice by the year 2000. The CNA formally endorsed the baccalaureate standard in 1982. Since that time, Kerr states that:

> the enthusiasm and eagerness to reach the goal by the year 2000 is evident as nurses from one end of the country to the other are identifying and developing mechanisms to ensure that logical, well-articulated, and reasonable plans are made for its achievement. (p. 261)

Unfortunately, Kerr paints a fairly rosy picture. Dickson (1993) argues that nursing leaders have incorporated the male physician ideology of patriarchal social order, physician as "expert", and the "natural division" of labor to the extent that it "divides nursing and confines its proponents to professionally limiting and ultimately self-defeating values" (p. 82). This can be observed in the existing tension between BScN prepared nurses and diploma prepared nurses, the

reluctance in the workplace to value nursing's perspectives on client care, and the lack of a cohesive view of professional nursing.

The baccalaureate standard as entry to practice could be perceived by students and nurses as dominant nursing leaders telling the 'masses' what educational path they must take. It could also be perceived that a baccalaureate education may provide a liberating education that consists of a 'freeing' of the consciousness.

The success or failure of the baccalaureate standard for entry to practice depends on the pedagogy of the educators. Freire (1993) states that educators must become partners of the students, recognizing that people are conscious beings, and that education is not the transfer of information but consists of acts of cognition. He notes that a liberating education causes students to feel challenged and subsequently they respond to that challenge. It is an educational process that affirms that learning is unfinished and that education is an ongoing activity.

Summary

The progress of nursing education has been greatly influenced by societal attitudes toward the education of women. Well educated women were (and are) threatening to many groups in society who reinforce the socialization of traditional women's roles in society. In addition, the internalization of these patriarchal societal attitudes by professional leaders also curbed the development of women's education.

Change occurs through the development of new values. Nurses need to look critically at their past, recognize the influences that have affected their value formation, and identify what values are truly important to them. Nurse educators have a responsibility to inform

students of the historical development of nursing and nursing education yet provide a culture that fosters nursing values without conforming to the traditional, patriarchal atmosphere that still permeates health care today.

CHAPTER IV

Literature Critique

> A teacher should be in the world learningly; to be open, always, to new possibilities, constantly transforming and being transformed. In this openness, teaching becomes learning, learning is hearing as in dialogue . . . and teaching is the struggle to understand. (Diekelmann, 1989, p. 38)

Traditionally, nursing education researchers have not used multiple research methodological paradigms to inform educational phenomena. The greatest diversity in research appears to occur in the method. Methods such as ethnography, grounded theory, hermeneutics, and phenomenology are frequently used in nursing education research (Beck, 1991; Davies, 1993; Diekelmann, 1993; MacKenzie, 1992). Although in many qualitative studies method and methodology are interdependent, research data are not often explicitly viewed through feminist, critical, or poststructural lenses. This is not to say that researchers do not value the assumptions of these research paradigms, rather, these assumptions must be teased out from the research itself. Conversely, some nursing education research that appears to be 'new generation' qualitative research is more closely aligned with positivistic research. As such, it describes social reality in a neutral manner.

The clinical setting provides an arena for the development of motor and intellectual skills and is considered essential in educating nursing students (Infante, 1985). Nursing students also confirm that the clinical setting is more useful to their learning than the classroom setting (Burnard, 1992a; Olson, 1983). Recent nursing literature about clinical education has begun to explore student perceptions about their clinical experiences throughout their baccalaureate education. These qualitative

experiences throughout their baccalaureate education. These qualitative studies in the literature are rich in detail and speak to students and educators alike.

The purpose of this literature critique is threefold. First, I will critically examine a number of articles related to learning (most having a focus on clinical learning) and identify the research paradigm(s) from which they operate. Second, I will examine the underlying assumptions and values of the research within the context of the trustworthiness of the data. Third, I will offer some insights on how the research might operate from a different set of assumptions and values within the educational process.

Nursing Education Research in the Interpretive Paradigm

Interpretive research is derived from the interpretive tradition of social inquiry which "seek[s] to replace the scientific notions of explanation, prediction, and control with the interpretive notions of understanding, meaning, and action" (Carr & Kemmis, 1986, p. 83). These same authors describe the purpose of interpretive social science as the means to make the meaning of people's actions transparent thereby facilitating dialogue between interested parties as well as providing individuals with alternative ways of interpreting their actions and defining their reality.

Kath Melia (1982) was one of the first qualitative nurse researchers to challenge the nursing profession to accept research which allowed for interpretive understanding of phenomena within nursing practice and the understanding of and insights into the student nurses' world. Melia assumes that there is "a missing wealth of rich data" which is not being

examined in nursing education and that this data can provide insights into the practice of nursing (p. 328). Using a grounded theory approach to analyze the data, Melia found that six conceptual categories framed the issues raised by the students from general questions such as "What is nursing all about?" and "What mattered the most in nursing?" The six categories include:

1. Learning and working. This describes the divide between the college of nursing and the hospital ward approach to nursing.

2. Getting the work done. This category concerns the students description of work on the wards.

3. Learning the rules. This category is concerned with how the students discovered what was expected of them on the wards.

4. Nursing in the dark. This category deals with the difficulties the students experienced in relation to talking with patients that stemmed from their lack of information about the patients.

5. Just passing through. This category concerns the transient nature of the student nurses' experiences during training. Transiency is used by the students in order to rationalize many of their unfavorable experiences as learners.

6. Doing nursing and being professional. This category seeks to explain what the students thought constituted nursing and what, for the students, makes a profession. Their descriptions of nursing can be summed up as thus real nursing, i.e. technically oriented work; not really nursing, i.e. social care such as that afforded long stay geriatric patients; and just basic nursing care, i.e. nursing care which is independent of medical prescription.

Melia's (1982) study is now 14 years old and was conducted in Great Britain, but the students raised issues that nursing educators still struggle with today; the perception of a theory-practice gap, the value of task-completion, student-patient communication, lack of information about patients, and the equating of high technical competence with excellence in nursing. As an interpretive piece of research, this study describes the understandings that student nurses derive from their learning experiences although the author did not explore the origins, causes and results of students adopting certain interpretations of their actions and social life (Carr & Kemmis, 1986), and neglected crucial problems with the social organization of nursing education.

Melia's (1982) study were analyzed from a critical perspective, it might offer students and educators insight into the relationship between the existing social order of the clinical area and the success or failure of the experience to meet the students' learning needs. The militarism of the British hospital could have been critiqued as a contributing factor to the isolation these students felt on the wards. In the 'chain of command', student nurses are ranked very low. A critical social perspective of this study would also provided analysis about the class structure of the health care providers on the unit. Monetary income alone stratifies physicians and nurses into different classes. Analysis of the invisible social expectations of nurses as women as well as designates within a particular class structure would have provided a greater social perspective on this data. As well, a feminist gaze on this data may have rendered visible the gendered construction of knowledge that led

students to perceive that "real nursing" is only related to "technically oriented work" (Melia).

Studies such as this confirm the need to hear the voice of the student so the perceptions of what we (as nurse educators) see accomplished in nursing education are similar or dissimilar to the perceptions of what students have of nursing as a profession. The interpretation of student experiences is a first step in uncovering and informing social actions, but is there a responsibility for nursing education researchers to look beyond the individual and identify sources of oppression that construct the 'realities' of these students?

Windsor (1987) conducted a study using naturalistic inquiry which interpreted nursing students' perceptions of the clinical experience. Naturalistic inquiry usually involves observing phenomena as it occurs in its natural setting or by listening to accounts of the phenomenon as it occurs for them (Streubert & Carpenter, 1995). Windsor interviewed nine senior nursing students who recalled their clinical experiences throughout their education. In general, the students enjoyed clinical experiences finding them valuable and personally fulfilling. Windsor found that clinical learning was facilitated when the student felt like a part of the health team and received positive feedback from instructors, staff, and patients even when they already knew they had done well. Students noted that lack of preparation, lack of support and supervision structure, and personal problems were detrimental to their learning in the clinical setting.

Windsor's (1987) study also revealed that student nurses move through different stages of professional development in clinical practice.

During the first stage students perceived clinical as a place to practice skills. Students felt very dependent on the instructor and unsure of themselves. In the second stage students became less focused on psychomotor skills and began to explore other aspects of the nursing profession. Some students were confused in this stage because they were unsure of what nurses do besides psychomotor tasks. The final stage of professional development in clinical was when the students became more confident and less dependent on the instructor. Their nursing role extended beyond the clinical setting and into their everyday lives.

The interviewer, in Windsor's (1987) study, as noted previously, asked students to recall their clinical experiences from the past four years and apparently worked under the assumption that the interviews were unproblematic: that students' recall of experiences was accurate. Scheurich (1995) critiques the traditional interview from a poststructuralist perspective noting that both researchers and interviewees have multiple intentions in an interview and that the language used by the researcher is unstable and can have different meanings to the interviewees at different times and under different circumstances. Scheurich does not intend to say that interviews are not appropriate sources of data, but that the researcher has to be cautious in assuming that interview data and analysis give a complete picture of the phenomenon in question. Windsor established trustworthiness of the data with a number of methods but did not acknowledge the fluid, changing nature of interviews which constitutes all of the data.

Windsor's (1987) study is valuable in that it interprets for educators situations that facilitate clinical learning for students and

what is detrimental to learning. Also, the study indicates that having a supportive relationship between the instructor, students, and staff fosters the positive aspects of interdependence. The influence of staff on learning experiences of novice student nurses is alluded to in this study. The question of whether staff are supportive of the learning needs of students within the context of the clinical environment and the power they have to influence positive or negative learning experiences for students could have been more fully addressed using a critical perspective. However, Windsor suggests that fostering supportive relationships at an undergraduate level may help establish closer working relationships between nurses in the future.

Building on Windsor's work, Wilson (1994) studied the nursing students' perspective of learning in a clinical setting where senior nursing students learned to provide care for acutely ill infants. The organizing theme derived from observation and ethnographic interviews was the idea of "perspective". Wilson described perspective as the "shared understanding of what the world of clinical nursing education was like for the student" (p. 82). This perspective provided students with an understanding of why they were in the clinical setting and what they could expect as outcomes from the experience. The students clarified that they had specific goals to achieve in the clinical setting but that there were two separate sets of criteria for evaluating their performance.

> Evaluation of a student performance by the instructor resulted in a grade. Evaluation of nurse performance focused on the quality of nursing care that the students delivered to their patients . . . The grade for the clinical course was the

> evaluation of their student role. Students perceived that their grade depended on how well they answered the instructor's questions and how well they did with charting and written care plans. As the students felt more competent in their nursing performance, they were able to discount any negative effect of the clinical grade on their goal of looking good as a nurse. (p. 84-85)

The value of Wilson's (1994) study is in its description of the students' perceptions of clinical evaluation. The dichotomy between evaluation of performance by the instructor and personal evaluation is, according to Wilson, consistent with the assumptions of symbolic interactionism.

> The social context of the clinical setting and the interactions that occurred there among students, instructors, patients, and staff were the basis for the meanings the students assigned to the learning process and to the roles each individual played in the clinical setting. There was a constant interplay between defining the situation (assigning meaning to people, things, and events) and responding to that situation. The nursing student perspective is a summary of the meanings that the students derived from their interactions in this social context. (p. 85)

Symbolic interactionism places the individual in the center of the text but recognizes that individuals interact within a larger network of individuals and groups (Manis & Meltzer, 1979). The critique by critical social theorists of this methodology for interpreting the results of the

study lies in the notion that, while it may be true that social reality is constructed and maintained through the interactions of individuals, it is also possible that the interpretations of reality open to the students may be constrained by the particular environment in which they are practicing (Carr & Kemmis, 1986). For example, the students expressed frustration with their limited abilities to practice certain skills for acutely ill infants in the study. The interpretation of skill acquisition as critical to learning (Wilson, 1994) may have been formed within the context of an environment that values skill acquisition above other forms of knowledge. Social structure itself produces particular meanings and actions of individuals (Carr & Kemmis, 1986) and therefore should be considered when analyzing social experiences.

Although Wilson (1994) works from a generally interpretive research paradigm, her concluding comments suggest that there is a greater social responsibility of nurse educators to reduce the dichotomy between practice-as-learning and practice-as-evaluation in clinical settings. She shifts responsibility from the individual to the social by identifying the need for change within educational programs. She encourages nursing educators to become more student-focused and less representative of the traditional power-based education model.

A phenomenological study of nursing students' initial clinical experiences by Beck (1993) specifically explored the lived experiences of 18 undergraduate nursing students to determine what was the essential structure of these experiences. The data were extrapolated from the written experiences of students during their first day of clinical practice. Beck found that significant statements in the written descriptions could

be organized into six clusters of themes: pervading anxiety, envisioning self as incompetent, feeling abandoned, encountering reality shock, doubting choices, and uplifting consequences. Five of these six themes identified are notably negative and provide nurse educators with insight into the power the clinical experience has to induce counterproductive feelings.

It can be questioned why these experiences are so negative and why the students felt so unprepared and unqualified to practice in the clinical area. Either a poststructural or critical analysis of these themes would raise concerns about the powerlessness students feel during their first clinical day. Critical social theory would focus on the social aspects of how knowledge and power are created and operate in a clinical environment and how this affects learning experiences. A poststructural gaze on this research would challenge Beck's (1993) assumption that an essential structure can be found in the students' experiences, free of any identified historical, social, or political context (Sands & Nuccio, 1992). However, Beck recognizes and provides suggestions for reducing the feelings of incompetence students experience and this research does allow nurse educators to "enter more fully" into the world of nursing students in their first clinical experience.

Walker and Kerr (1994) report their findings of a case study of senior (practicing) and junior (student) nurses' conceptual abilities in day-to-day nursing activities. The authors concentrate their research efforts on investigating students "acquisition of clinical knowledge and skills" from an inductive approach or one that is grounded in data (p. 1120). The authors use a triangulated method of analysis of qualitative

data consisting of reflective diaries, semi-structured interviews, and discussions about critical incidents in student clinical experiences. Although this study does not clearly state its research paradigm, I would argue that it belongs in the interpretive research paradigm for the following reasons.

First, the interpretive view of research does not reinterpret the actions and experiences of individuals but "rather provides a deeper, more extensive and systematized knowledge and understanding of the actor's own interpretations of what they are doing" (Carr & Kemmis, 1986, p. 92). Walker and Kerr (1994) make no attempt to identify or explore how the work of learning nursing is accomplished between social actors (i. e. other nurses, patients, physicians, etc.). The analysis is limited to exploring the level of conceptual differences between senior nurses and students. The research provides a means of revealing to students and nurses the authors' interpretation of how these groups think about what they are doing in clinical practice.

Second, Walker and Kerr's (1994) study fits into the interpretive paradigm by trying to "uncover the set of social rules which give point to a certain kind of social activity and so reveal the structure of intelligibility which explains why actions being observed make sense" (Carr & Kemmis, 1986, p. 89). The authors identify that students and senior nurses conceptualize their practice differently. They identify advanced conceptual thinking as a result of acquiring concepts in a hierarchical manner and making informed plans of action. Therefore, Walker and Kerr "make sense" of student behavior by applying these rules of concept acquisition in a nursing practice situation.

Walker and Kerr (1994) assume that the manner in which content is being taught to students is adequate (as they offer no critique of it), but they identify that there is some kind of failure on the part of the students to apply content. Students believe that this lack "of essential information with which to make sense of even . . . apparently simple tasks" (p. 1121) lies with them. There is no attempt by the researchers to question the social construction of what is accepted as appropriate behavior and knowledge (Kempner, 1992). The structuralist notion of placing students at certain conceptual levels ignores any situational context to learning and does not begin to communicate the dynamics of student learning (Lauder, 1996). By failing to bring the social into the analysis of these data, these authors exclude examination of the influence of socially constructed knowledge in nursing, and obscure the potential understandings that should emerge from the interactions.

Mezirow's (1981) theory of adult learning, based on Habermas' critical social theory, might have provided a critical perspective from which Walker and Kerr (1994) could interpret their research findings. In general Mezirow believes that there must be a "sustained effort to assist adults to learn in a way that enhances their capability to function as self-directed learners" (p. 21). I believe that if this kind of assumption were used to underlay Walker and Kerr's research there would have been less blame placed on the student for failing to meet the conceptual standards of senior nurses and more emphasis placed on challenging the power imbalances and domination that occurs in clinical learning situations.

A poststructural perspective of Walker and Kerr's (1994) research would challenge the construction of experiential knowledge as

represented by the dichotomy between experienced and inexperienced nurses. Cannot every nurse (or student) be, at the same time, experienced and inexperienced? Analysis from a poststructural perspective would question whether the values of student's "being tidy" or "organized" are the values nurses really hold, or if they were constructed to serve the purposes of what Dorothy Smith (1988) calls the ruling apparatus. Poststructuralism challenges us to think about who we are and how we are constructed and constituted (Kohli, 1991).

Feminist theory would also provide a slightly different perspective to Walker and Kerr's (1994) research as feminist assumptions would make it necessary that the results from the study be viewed within the context of the patriarchal construction of health care institutions (where most clinical education occurs). Clinical teaching, therefore, cannot be an entity unto itself but is intricately related to the environment in which it occurs. As well, the feminist process would make visible the "differing realities and understandings of researchers and researched" and "question the complexities of power in research" (Stanley & Wise, 1990, p. 23).

A unifying feature of all these research studies is the assumption that the curriculum guiding student learning does not need to be changed. There are suggestions for changing teaching methods but not changing the overall philosophy of nursing programs. For the last 40 years most nursing programs were grounded in behavioral theory which bases learning on specific behavioral outcomes (Hill et al., 1994). This behavioral approach to learning tries to control students by having them meet predetermined objectives regardless of the varying goals and

experiences of students (Allen, 1990). The deficits of this teaching paradigm have been identified by a number of prominent nurse educators over the last 10 years (Allen, 1990; Bevis, 1989; Diekelmann, 1990; Tanner, 1990a). Diekelmann (1990) suggests that if curriculum revolution is to occur there must be a commitment to caring, student-teacher dialogue, and expertise in the practice of teaching within nursing education. Through the use of alternative research paradigms, nursing education researchers may raise awareness of the greater social issues that influence nursing education and provide impetus for curricular change. The following section describes nursing education research related to student learning using alternative research paradigms.

Nursing Education Research in the Critical and Poststructural Paradigms

There is a small body of nursing education researchers who are beginning to conduct research and analyze data from alternative non-traditional (non-positivist) research paradigms. The most obvious commonalties between these pieces of research are the use of multiple voices in the research texts, the use of qualitative research methods, and the recognition of the social and political influences in nursing education. I could not locate any research related to clinical nursing education that specifically used feminist research principles although some of the researchers identified that this research paradigm could add to the research process.

Most of the research that fits into the critical or poststructural research paradigms began in the late 1980s and early 1990s. In 1990 Nelms initiated a study the purpose of which was to "provide a

theoretical base on which nursing education could incorporate the lived experience of nursing students into its curriculum through phenomenological methodology" (p. 286). Nelms interviewed 17 baccalaureate nursing students in all levels of a generic program. The analysis of the data showed that the commonalties of the students' experiences "revealed a collective transbiographic phenomenon" (p. 288). The six categories which describe this phenomenon are as follows:

1. A life-pervasive intensive commitment, or the sense that there are almost insurmountable amounts of knowledge to be mastered. And that this mastery of knowledge has to occur within a set criteria and within a certain time frame. The theme that emerged from this category was that students had to put their lives on hold while in the baccalaureate program.

2. The meaning of clinical, that is, that the most meaningful aspect of the lived experience of being a student were the clinical experiences. Clinical was the time that all the work in class and preparation was focused on caring for their patients and developing their sense of self as a nurse.

3. Personal knowledge experiences, or when nursing knowledge finally became their own knowledge.

4. Support systems. The most important support system the students relied on during their educational experience was other students. Students experienced a sense of camaraderie with each other against the educational system. It was expressed as a sense of "toughing it out together" by one student (Nelms, 1990, p. 293).

5. Feelings about self, or the knowledge gained by self-reflection about why they wanted to be a nurse. This category is a description of the sense of accomplishment students gain and how if affects themselves and others around them.

6. Ideal teacher. This category describes the expectations of those who teach them. The students have many expectations but most notable is the expectation that teachers have to value nursing knowledge and competency but never more they value the student as a person.

Nelms (1990) approaches this study from the perspective that the curriculum in nursing at present is not adequate and needs to be reconceptualized. She critically analyzes each category developed from the data and offers guidance for reconceptualizing the nursing curriculum so that there is a focus on sharing the lived experiences of students and a de-emphasis on the traditional activities that "perpetuate power struggles in nursing education" (p. 290). Nelms states that curricular reconcepualization "must be accomplished by nurse educators who believe that the creation of more just nursing education is our part of making a more just public world" (p. 297).

In her concluding remarks, Nelms (1990) addresses the need for "raising the nursing education consciousness" (p. 296). Consciousness raising is central to feminist research (Cook & Fonow, 1990) and, although Nelms does not identify the research as being feminist in nature, a feminist gaze on this research may provide a more complete view of women's social reality within nursing education.

MacKenzie (1992), in an ethnographic study, examined the experiences of district nurse students in the learning environment of the

community. She used an adult learning theory to frame the research but recognized that the humanistic philosophical foundations of adult learning theory has an individualistic nature and that experiences cannot be examined without identifying the social and political context of learning. Based on the previous statement and MacKenzie's reference to critical writers such as Schön, Mezirow, and Kemmis, I would argue that this research would be included in a critical research paradigm although this is not explicitly identified.

Combining data from observation, individual interviews, and group interviews, MacKenzie (1992) identified three categories that described the learning process in becoming a district nurse. The categories were "fitting in", "trying and testing out", and "reality of practice". "Fitting in" is described as the process of the students to fit into the social environment (with colleagues, patients, and routines). Strategies for fitting in included keeping a low profile, not asking challenging questions, and trying to act interested. The second category identified was "trying and testing out". Learning by doing was noted by students as essential to the learning process. Learning through self-direction, however, is identified as being useful only when it is purposeful and when students know what they have to learn. The "reality of practice" was highly valued as a learning resource by students. However, students were critical of both college and practice, i.e. the theory-practice gap and the gap within practice.

Each of the categories that MacKenzie (1992) identifies as being conceptually linked to adult learning theory are explained within the social and political context of the students' experiences. By critically identifying the potential social and political barriers to learning,

MacKenzie provides nurse educators with the knowledge and awareness to prepare for barriers in their own education practice. Had feminist assumptions had been used to inform this study, it would have been necessary to view the results within the context of the patriarchal construction of the health care system where nurses practice and students learn. Clinical learning is not context-free but is intimately situated in the environment in which it occurs.

One of the foremost advocators of nursing curriculum revolution is Nancy Diekelmann. She has been using the Heideggerian hermeneutical research process to analyze the lived experiences of students in her published research since the late 1980s. Initially this analysis would appear to be interpretive in nature because hermeneutics is a technical method of interpreting behavior (Carr & Kemmis, 1986). I would argue, however, that her research is located in the critical and poststructural research paradigms. Diekelmann's analyses goes beyond simply understanding meanings within a text to uncovering and making conscious some of the contradictions and hidden power relations that are embedded in the text. Her description of hermeneutical inquiry suggests that it both situates learning and empowers participants as they "struggle to understand" (Diekelmann, 1989, p. 25). It is a research method that analyzes the voices of the participants to uncover hidden meanings and relationships.

The learning associated relational themes that emerged from data of three studies she undertook with nursing students and faculty in baccalaureate nursing programs are those of "learning-as-evaluation" (Diekelmann, 1989), "learning-as-testing" (Diekelmann, 1992), and

"learning-as-cognitive-gain" (Diekelmann, 1993). Embedded in all three pieces of research are common assumptions she holds about knowledge and learning, evaluation, clinical practice, and student-teacher relationships.

Diekelmann (1989, 1992, 1993) expresses concerns about the predominantly traditional behavioral pedagogical approach toward learning. "Learning-as-cognitive gain" is described in the 1993 research study as the accumulation of knowledge and its associated application without recognizing the context in which it is applied. Instead of focusing on thinking and learning about what they consider meaningful, the students focus on the priorities of the instructor (Diekelmann, 1992). Learning often becomes defined in terms of the instructor rather than themselves. While Diekelmann recognizes that some rules are useful to learn as a means of helping students enter new situations safely, she does not support the notion of linear thinking. Diekelmann describes thinking as "a path that becomes involved with content in context and adapts, rejects, and transforms it by attempting to explicate particular contexts" (1993, p. 247). She contends that by focusing on content rather than on transformational thinking "our teaching practices may conceal what is being learned, or rather the meanings that the student is taking on are systematically covered over" (p. 247). Diekelmann also identifies that the understanding of what constitutes knowledge is also covered over. According to her, knowledge is not neutral and therefore content decisions cannot be neutral even though behavioral pedagogy suggests they are.

Another assumption that is embedded in Diekelmann's research is the ineffectiveness of evaluation strategies to represent student learning in a behavioral curriculum. Evaluation is experienced as adversarial by all types of students (Diekelmann, 1989, 1992). The traditional behavioral model of nursing education encourages a teacher-centered relationship, giving the teacher final power and authority, which perpetuates adversarialism (Giroux, as cited in Diekelmann, 1989). Diekelmann (1989) advocates that nurse educators discuss with students the meaning of evaluation. "Perhaps understanding the students' lived experience and the meanings of evaluation will help us transform evaluation as a part of practice in teaching nursing" (p. 27). A constitutional theme that emerged from Diekelmann's (1992) research of the lived experiences of students and teachers in nursing was "learning-as-testing", i.e. testing has become the equivalent of learning. The themes that were derived from these data seem to be applicable to all areas of nursing education including the clinical area. The themes included: feeling overwhelmed, getting the right answer, and testing as teacher-centered learning. In this study, both teachers and students expressed their concerns about testing practices. "This study reveals that what matters in teaching and learning are the practices we create as teachers and how these practices are experienced by the students" (p. 75).

Diekelmann (1989, 1990) makes an important argument for examining and understanding the learning that is embedded in teaching practice. A common underlying assumption of all the pieces of research is that clinical experience is necessary for learning nursing practice.

However, the data is analyzed without the distinctions that race, class, age, gender, and other social situations may bring to the results. The research articles do not identify any detailed demographic data about the participants in the study making the experiences that these students bring into the study silent. However, suggestions for improving clinical learning experiences for students are provided for in the articles. Diekelmann's (1993) suggestions are made under the assumption that pedagogy in nursing education must change so that value is placed on contextual thinking and learning. She asserts that if teachers developed hermeneutic skills - hearing rather than listening - then the dialogue between students and teachers would open up new possibilities for students as they study nursing.

Diekelmann appears to enter the research valuing a non-hierarchical student-teacher relationship, as evidenced by her criticism of the traditional model of education. In the traditional model teachers are viewed as knowing what is best for students and students are viewed as passive recipients of knowledge (Gaines & Baldwin, 1996). In opposition to this model, Diekelmann's aim for nursing education incorporates ongoing dialogue between students and teachers. Diekelmann's (1993) use of the word "dialogue" is, in itself, representative of a non-hierarchical student-teacher relationship. A dialogue, or an exchange of ideas or opinions, implies that power is shared relatively equally by the participants. This dialogue will mutually identify the kinds of knowledge and understanding that needs to be in a nursing curriculum. Diekelmann (1989) advocates a transformative curriculum that consists of multiple voices coming together to discuss

concerns about nursing education and to explore new possibilities in teaching and learning.

I find Diekelmann's research very powerful. The assumptions that underpin her study are progressive but it is possible that this research could be informed to a greater extent through the use of feminist research methodology (she identifies this as well). Feminist methodology would view nursing education from the political perspective that its construction is intimately tied to women's work. Feminist theory identifies that socially legitimized knowledge is constructed by dominant social groups and general social knowledge has been generated without the perspective of women (Harding, 1991). Chinn (1989) describes transformation education as being open to new possibilities and having a skeptical stance toward everything that we have previously thought and known.

> The attitudes that are thought of as important to instill in students are identified as valuable for learning because they are attitudes that serve us well in male-defined situations. The "logic" that is thought to characterize the educated mind is a logic of masculinist thinking. (p. 12)

Summary

The research reviewed in this chapter attempts to extend the present understanding of student learning. There is other research in specific areas of student learning such as critical thinking (Sedlak, 1997), professional socialization (Campbell, Larrivee, Field, Day, & Reutter, 1994), and self-reflective learning (Landeen, Byrne, & Brown, 1995) that offers insight into specific student experiences. The purpose of

the critique is to highlight the range of research done rather than to capture a total picture (if that could ever be possible).

The process of locating each of these pieces of nursing education research in their respective research paradigms was not, nor could it ever be, objective. I brought into the process my own assumptions and values about nursing education research. I believe that nursing research has to become more critical in nature and, as such, the gendered historical, political, and social context of the research must be present in the text. A few months ago, Walker and Kerr's (1994) research, for example, would have been perfectly credible to me and would have explained my frustrations with beginning nursing students' practice. However, it takes research such as Diekelmann's to help me recognize that teaching is not simply a transaction between the student and myself but has to be considered within the complexities of the social world that has been constructed around us. Whether these authors would agree with how I re-focused the research lens on their study is up for debate, but the process itself helped me realize how little I challenge method and methodology in the research I read.

CHAPTER V

The Ethnographic Setting

Historical Location

Before describing the ethnographic setting I believe that it is important to place the setting in its historical context. The meaning of learning experiences for the students in the study do not appear to be separate from the history of either the school of nursing where they are enrolled or the clinical environments where they practice.

The town where the Bachelor of Science in Nursing (BScN) program is located is a significant distance (300 km) from the major university with which it collaborates. In the past, the town has had a flourishing fishing, textile, and farming industry base. There was steady ocean traffic between a large US city and the town. The economic stability of the area has decreased with the closure of most major industries except for fishing (even here, a significant decline). At present, the hospital complex is the largest employer in the region.

Since the early part of the century there has been a diploma nursing program at the hospital site in this particular community. The program began one year after the general hospital opened. Recently the last class of the diploma school graduated, bringing the total number of graduates to 1272 over the 82 year period. The diploma program had a fairly high profile in the community. Many local residents attended the school and then worked for the hospital organization. The baccalaureate nursing degree program is now offered at the same location as the diploma nursing program. However, it is perceived by the students in this study that the BScN program is much less visible in the community than the diploma program.

> Half the people think that the RN program still is here and the other half don't think that there's a program at all. Lots of people still think that the BScN program isn't as good as the diploma program. My friend said that because she has a diploma that she'll be the better nurse (Casey).

The student participants in this study are in a unique position. They are the first class enrolled in a locally offered collaborative BScN degree program in this small community. There are no other groups of student nurses who have experienced the baccalaureate program to draw on for assistance or guidance. There is no other method of obtaining a generic baccalaureate nursing degree except through this program. Students refer to themselves as "guinea pigs" for the degree program.

In the regular academic year, the students attended classes offered by universities other than the major university offering the collaborative nursing degree. The link between the major university and the students at this distance campus site is tenuous. The students' frustrations were not dissimilar to many distance students' frustrations.

> We're not part of the university . . . we don't even get the campus newspaper. It's not sent here (Sara).

> On the other hand, we can't breathe without getting the university's permission (Ellen).

> The faculty keep stressing that we're part of the university but we don't feel part of it. We even have to graduate with the other university students. We had our pinning ceremony here but no one from the university came down. One of the instructors had to do it (Sara).

Although the students do not have strong ties to the university, they enjoy the opportunity of having the baccalaureate program offered in the town. Some of the students did not want to go to a large city for financial as well as for family or relationship reasons. Other students

started the program in the city but did not like that environment and returned to this area. The students recognized the advantages and disadvantages of having the program offered at a distance site.

> We're a small group so that is definitely a big factor. Well, I've been in larger groups and the closeness isn't there. You become this little family with each other. You feel more comfortable with the instructors. You feel like you can, ah, offer your advice, your information, and get your questions answered or whatever more freely (Ellen).

> One of the bad things being here is the problem with getting articles. They give us 10 free interlibrary loans and then after that we have to start paying. The library here has some stuff but not much, not like the university (Casey).

Current Program Structure

In this section I will not present an analysis, rather, what follows is a straightforward presentation of the structure of the initial clinical course as seen through my eyes and via the voices of the students.

Nursing 120 is a clinical course that was offered in the spring semester following the first year of this particular BScN program. The course was three weeks long and consisted of essentially three components. The first component focused on the helping relationship and the dynamics of therapeutic communication (with an associated videotaped communication lab with actors). The second component of the course was the demonstration and practice of psychomotor nursing skills such as hand washing, bed making, moving, lifting, and transferring of clients, and bed bathing. The third component of the course was the clinical practicum or clinical application of communication, caring and psychomotor skills.

The course content was delivered through lecture, group discussion, laboratory demonstration, videotape feedback sessions, and clinical practicum. The 50 page course outline and study guide included 56 required readings from two major texts and numerous journals. The course had six major objectives for the students to attain which were further divided into 86 behavioral objectives for classroom content, 35 behavioral objectives for the laboratory skills content, and four major clinical behavioral objectives further subdivided into 15 specific clinical behaviors.

The evaluation of the course content was broken into four components: a journal assignment, a nursing health history, a practical (videotaped) exam, and a clinical grade. The pass mark for the course was a letter grade of "C". There was no formal evaluation of the lab skills component of the course.

There were two written assignments expected from the students. The journal assignment guidelines consisted of 16 questions that when answered were to describe one lived experience which occurred during the student's first day of clinical. The journal assignment was weighted at 10% of the course. The nursing health history assignment was a 24 page form consisting of two sections: data collection and data analysis. The data collection section of the health history was comprised of 18 categories of information that were to be obtained from a clinical client. The data analysis section consisted of the student's assessment of the client's health and growth and development, the student's description of the application of informed caring, and a description of how one principle of primary health care is relevant to the client's situation/lifestyle. The

health history assignment was worth 20%. The practical exam required the students to conduct a ten-minute interview with an actor on videotape. The student's performance was marked according to 25 criteria ranging in weightings from "giving his/her name" (.25 marks) to "summarizing content of interview" (3.00 marks). The total for the assignment was 30% of the course mark.

For the students to successfully complete N120, they had to obtain a minimum mark of "C" in the clinical component of the course. That meant that they had to have an average of 8/10 on each of the four clinical objectives (32/40). To receive an "A" for the course the students had to receive a 10/10 on each of the four clinical objectives. A mark of 10 was "reserved for (an) outstanding student who excels in a criterion". The clinical evaluation tool provided space for the students to record their perceptions of areas for further development for each objective as well as the faculty member's perceptions about the student's areas for further development. There was some concern verbalized by the students before the clinical evaluation about the mark allocation process. For example, when a mark of 8 was given for two of the clinical objectives and a mark of nine for the other two, the average was 8.5. The students were concerned that they would get a "C" even though their mark was higher than a "C". During the clinical evaluation on the last day of the course, the students found out that they would receive a mark out of 40, based on the average of the four marks they received for each clinical objective. All of the students passed the course.

Learning Environments

Throughout the ethnography I placed myself in locations adjacent to learning environments. I interviewed and talked to students in these settings and about these settings. The formal learning environments consisted of the classroom, lab, and clinical. Informal environments such as the lounge, cafeteria, library reading room, and student kitchen provided a relaxed "backstage" area for students to discuss their educational experiences.

The clinical lab. The lab consisted of one open room with five hospital beds, a sink, counter, med cart, locker, and dirty linen cart, and a podium. The hospital beds were made up in white sheets and were in the high position. Two of the beds had over bed tables. There was a portable blood pressure cuff and sphygmanomometer. There were assorted anatomical models on the counter. There were two bulletin boards on the wall with a completed health history pinned on one board. The lab area was used for psychomotor skill demonstrations and practice, pre- and post-clinical conferences, and as a practice area for conducting therapeutic communication scenarios.

The students were not required to wear lab coats during lab demonstration or practice sessions. There were no requirements for hair styles, permissible jewelry, or dress code. The students were provided with lab demonstrations of hand washing, hygiene, and bed making according to the course guidelines. The students also fed each other lunch one day and recorded intake on a flow sheet. In addition to the course requirements, they were shown how to safely move and lift patients in and out of bed.

The classroom. The classroom used by this class had been used all year and even though the class size was larger this spring, the students wanted to remain in the smaller of two classrooms available at the School of Nursing. One student explained it as such:

> Erna: I like it. I like the classroom. The first couple of days when we had --, we were doing just lecture all day long she wanted to switch us to the upstairs classroom and we were all like "no way, we're not moving, this is our room". None of us wanted to go because we really like that room and it seems to do something for us.
>
> Researcher: Can you describe "something"?
>
> Erna: It's a real comfortable room. Like the way they have all the tables in a group and we have chairs with arms and you've got a big writing space. You haven't got this little 6 by 6 spot. You know, the sun comes in the windows and the professors, they don't always turn the lights on and if you want the lights off they'll turn them off, it doesn't matter. We can open the windows and close the windows. You know, it's not like being in a concrete theater with a harsh bright fluorescent light and no fresh air listening to a professor screaming into a microphone. It's like a really comfortable room.

The classroom was located in the basement of the school of nursing. There were six windows that provided a view of the ground outside. There were four tables pushed together to make one large table and seventeen chairs were positioned around the table. There was plenty of natural light and salmon pink walls. The seventeen chairs made it cozy around the table and everyone was elbow to elbow. There was a TV, VCR, and flip chart at the front of the class. There was also a white board, and a film screen at the front. There were pictures and a clock on the wall. The students said they wanted to stay in the class because they liked the feeling of closeness. The room upstairs was too big and it made

their class seem too small, whereas this classroom made their class seem larger.

Clinical environments. The students in the study cared for patients in both acute care settings and extended care settings. The acute care unit consisted of 31 medical beds, divided into three nursing teams. Team 1 had a RN team leader and other RNs and CNAs who cared for patients on the three- or four-bed ward end of the unit. The composition of all the teams was similar. Team 2 was also located on the ward end of the unit. Team 3 was located on the private end if the unit. All the rooms were private on this team except for one double bed room. The students were allocated patients throughout all three teams. According to one student, students were usually aware of only the patients on their team.

> With some patients you didn't know a thing about them. You didn't know who they were, you didn't know what they were there for. But then, like others, you kinda grew on like Sara's patient. I knew her and went to talk to her frequently. I always went to talk to her, she's was nice. So I knew her and I knew Jane's patient. Like Ellen's patient, I didn't know Ellen's patient, like I didn't know any of them. I think it's on your ward. The team. I think I knew most of the patients of students who were on my team . . . . I knew what was going on with them but on the other side, no. You don't (Casey).

The layout of the unit consisted of a central nursing station intersecting the two "ends" of the unit. The head nurse or charge nurse was present at the nursing station as well as a ward clerk. There was a panel of lights on the wall and when a patient pushed the buzzer in his/her room the light would glow and the buzzer would sound. The nursing station was long and narrow with racks for charts, filing cabinets, shelves, desks, and benches lining the walls. There were two

phones, a tape deck, a stamping machine, and pads of paper on the desks.

Taped report of the patient activities on night shift occurred at 0730 in the nurses' station. The limitations of the physical space prevented students from listening to the complete tape recorded information.

> We can't all fit in the area where taped report happens. There are a bunch of nurses and us and so after we hear our team's report we have to leave (Sara).

Some of the students returned to the nurses' station after report was over and the staff had left so that they could discuss their plans for the day with the instructor. The location to the rear of the nurses' station was used by the students as a place to review charts, to work on their assignments, and to talk to each other.

The extended care facility where the second group was situated for the clinical component of the course is attached to the hospital complex. The unit is comprised of 35 residents requiring different levels of assistance from health care workers. Some of the residents were mostly independent while others required total personal care be done by personal care workers and registered nurses. There was no nursing care team structure on this unit. There was one RN who was the manager and the rest of the staff were comprised of personal care workers.

The nursing station consisted of a small desk and elevated counter with three chairs positioned behind. It was located about half-way down the hallway. There was a call board that displayed the room numbers of the residents that lit up when the buzzer was pushed in the resident's

room. A small clean utility room was located slightly to the side and behind the nurse's station. The station had a phone, shelves, drawers, and a coffee pot.

Students met at the nursing desk at 0730 each morning. and checked the resident assignment list. After only three days in the clinical area students self-selected the residents they were to care for. There appeared to be a core number of residents selected by the instructor but any other additional assignments were chosen by leafing through the kardex and, based on the information there, (usually if the resident required assistance "but not too much"), a selection was made.

> Erna: We know most of the residents by name, even if they're not assigned to us.
>
> Researcher: Where are you getting your information from to prepare?
>
> Erna: We got information from the instructor the day before so we had an idea of what to do and then when we came on the unit the first day and got information about their usual routines.
>
> R: How did you get information about their usual routines?
>
> Erna: There is report in the morning - later- about what bath they need, help that they need, and stuff like that.
>
> R: Did you just wait that first day until report?
>
> Erna: Ya, we just waited around until report was given. Now we go help with breakfast and then come back to the desk to get report.

Unlike in the acute care setting, the students were more aware of the residents living in the extended care unit.

> We've only been here four days and we know almost everyone. We feel comfortable answering call bells and going into other resident's

> rooms. It doesn't bother us. We feel like we can cope with just about anything we go into (Erna).

Other environments. Much of the observation time during this ethnography was spent in environments other than formal teaching settings. I had anticipated that the students would spend quite a bit of time in the student lounge but the course schedule was very concentrated and students were in class from 0900 to 1600 most of the nine days of class and lab. I observed and talked to students during breaks between classes, after class, and during unsupervised practice sessions in the lab. During the clinical practicum component of the class I had a greater opportunity to observe and talk to students when they were not actively caring for clients. The students would sit with me when not busy and talk about their experiences. I also accompanied them to the cafeteria for breaks. The backstage atmosphere was conducive for discussion and provided an opportunity for students to reflect on their frontstage activities.

In summary, this chapter provides the reader with some awareness of the smaller and larger units within the subculture of novice nursing students as well as the macro structures of the town where the school is situated. In the next chapter I will describe, analyze, and explore this sub-culture thematically. The aim of the chapter is to give voice to the students' learning experiences in their words as well as forum for the analysis of their experiences.

CHAPTER VI

Analysis

> We must hear women speak of their experience if we are to understand their meanings and perceptions. Their descriptions and interpretations come from living in the everyday world - in a body; in time, space, and place; in a situated context. (Munhall, 1995, p. xiii)

This chapter is a thematic account of the lived learning experiences of a number of student participants during an initial clinical course. As with any written document my subjective position as the writer has influenced the account of the lived experiences of the students. Therefore the meaning of the analysis comes to exist in the space between the reader and the text - the text that I have constructed from the ethnographic data.

As alluded to in the preceding chapters, the social construction of knowledge and learning is complex. Analysis of such complex relations starts, as recommended by Smith (1988), at the entry point of a few particular people where the everyday world of working (or learning) is locally organized. The aim of the analysis is to build and expand on the material collected from these participants and to look at it from a variety of perspectives. Goffman's (1959) metaphor of the backstage and frontstage parts of a performance will thread through the themes that emerge from the data. Feminist, critical social, and poststructural perspectives will be used to explore and examine the themes in an attempt to look to greater social influences on the lived experience of learning in an initial clinical course. The analysis of these themes serves a dual purpose. It provides an opportunity to hear the voice of students describing their experiences of learning in an initial clinical course and it

describing their experiences of learning in an initial clinical course and it serves as a forum to discuss directions in alternative curricular development in nursing education.

I believe it is important to note that I do not want the readers of this thesis to be under the impression that I am critiquing individual instructor's teaching methods of specific learning activities within this initial clinical course, but rather, I am looking at the data in terms of the more problematic curricular issues confronting nursing education. The central issues of power, gender, and class are of primary concern.

The ethnographic data were sorted into three major themes with a number of sub-themes in each area. The title for each major theme was an expression used by a student as she described her learning experiences. Although I have divided the themes into sections, the themes themselves overlap and interrelate. In the following pages I will describe and analyze each of the themes using student participant comments, my observations during the research, artifacts, and sources of nursing, educational, philosophical, feminist, and sociological literature.

"Being Watched and Marked"

A theme that repeatedly surfaced throughout the analysis of ethnographic data was related to students' awareness that many of their actions were being watched, or both watched and marked. The knowledge that their behaviors were being watched affected them throughout most components of the course. Although the students interacted well with the instructors in the course, they were aware of the instructors' presence in learning environments and the power instructors

held in determining their marks. The student-teacher power structure will be analyzed using Foucault's writings about organization discipline (as cited in Rabinow, 1984).

Nursing education has been, and is located in, health care and educational institutions. Both of these institutions have intricate hierarchical structures and use power to achieve organizational goals. Within these institutions nursing is defined as a "discipline". Foucault notes that the word "discipline" can be defined as both a type of punitive power or as a branch of knowledge. Foucault's writings focus on the meaning of discipline within the context of power and his observations can be related to the difficulties student nurses confront in their education.

Foucault argued that through the use of simple instruments by institutions, disciplinary power is maintained. There are three instruments of discipline that work to maintain the status quo: hierarchical observation, normalizing judgment, and examination.

Hierarchical observation by those at the top of the power structure seeks to ensure that the individual can be seen at all times. This ability to observe supports disciplinary power. Foucault's use of the term panopticism helps explain how hierarchical observation operates. Panopticism is a modality of power that is used by those in authority to "discipline" society. It is a method of bringing the effects of power to the most "minute and distant elements" (p. 207). The goal of panopticism is to discipline people to act in such a way that it creates both productivity and docility at the same time. This desired behavior is, of course, socially constructed.

Normalizing judgment is an instrument by which strict adherence to "correct behavior" is demanded and any departure from this behavior is punished in some manner. The "art of punishing" is not necessarily to repress but to "refer individuals to that which is at once a field of comparison, a space of differentiation, and a principle of a rule to be followed" (p. 195).

The third instrument of discipline is examination. Examination combines the techniques of observing hierarchy and normalizing judgment. Through examination the actions or characteristics of an individual are compared to others or to a norm (Dzurec, 1989). Examination "establishes over individuals a visibility through which one differentiates them and judges them " (Foucault, as cited in Rabinow, 1984, p. 197). Each of these disciplinary instruments are used in some manner in nursing education (Dzurec, 1989).

Foucault's work was particularly relevant when I was analyzing this theme of "being watched and marked". The experience of being watched and marked was different for students in the various components of the course. In some instances students were neither watched nor marked but that situation was relatively rare. Each of the sub-themes will explore the students' different experiences of "being watched and marked".

Being Watched by Others in Class

Within the classroom setting a large portion of time was spent on learning about and practicing communication skills. Lectures and discussions were directed toward learning about the helping relationship and communication techniques. As well, students were expected to be

videotaped while interacting with a client/actor. To prepare for this new experience, students read a brief patient profile, entered a room with an actor/client and engaged in a five minute therapeutic conversation using a set of 25 guidelines that encouraged the use of warmth, empathy, and respect throughout the interview. Being able to watch themselves communicate and to have others watch them was a positive learning experience for some students but for others it was a source of anxiety.

> The videotapes helped a lot [to facilitate learning] because you get to see . . . because you get to come back in and get to watch it and you get to see yourself and say, oh, I probably shouldn't have done that. Or, I should have done that differently. And I find it's a lot easier to learn from your own mistakes than from someone telling you that you should have done it a different way. So I think that's probably one of the main reasons why they did the videotape situation and I guess that's what I like about it . . . . I think though that the camera causes a lot of anxiety. Just the fact that it's a **camera**, but, then again for grading purposes they [the instructors] can't do it any other way. So it's just something that can't be changed. It's just a rule that we have to accept. But I know that some of the girls feel the opposite way. So, I think it's just personal preference (Erna).

It is documented in the literature that videotaping produces anxiety for many students although they still considered the process valuable to their learning (Carver & Tamlyn, 1985; Finley, Kim, & Mynatt, 1979). The previously cited studies also noted that students and instructors needed to develop a trusting relationship so the critique of the tape would be a positive learning experience. The students in this study had to trust both the instructor and their peers as an audience during the taping sessions. Trust became an issue for one student in particular.

> I get really tired from being anxious waiting for my turn to do the videotape. We also need to build up some trust in the groups. We've been in classes with each other but not like this. This is all day long and we're just getting to know everyone. There are a couple of students who have just come here and we don't know them really well yet (Ellen).

The students generally experienced difficulty performing a taped therapeutic interview with an actor in front of the group but, interestingly, the students watching the interview were also uncomfortable at times.

> Researcher: What was it like to watch the other students [during the taping]?
>
> Ellen: That bothered me. . . . I never say a poor word about anyone, I'm not going to laugh, but I know what they're going through because I can see that they're anxious, in their eyes and everything, Say they're in there and they're stumbling on their words, my heart starts beating fast. . . and I get, you know, kind of anxious for them. That's kinda hard because you know how hard it is for them.

As well, the presence of the actor seemed to interfere with the quality of the learning experience for some of the students. Some of the students knew the actors socially and had particular trouble playing the role of the student nurse. Their perception of being watched was extended to include the actor.

> You know what was kinda hard with that [being watched] is that me and Casey both knew the actor. If we didn't know her or hadn't seen her before I think we would have been able to role-play better (Sara).

Due to a combination of factors; the new experience of being videotaped, trust issues, and some students knowing the actors, there was the belief that the quality of the value of the learning experience was diminished (for some students) by having an audience. In both Carver

and Tamlyn's (1985) and Findley et al.'s studies the interviews were observed only by the instructor. According to the students in the study, there is greater personal risk when the audience is larger.

One student expressed her concerns to the instructors about her perception of the difficulties the class was having with the taped communication interchanges but the others only commented on the experience in the backstage arena. It was their opinion that the best way to learn about nurse-patient communication would be to first practice with other students they trusted in a small group and then move into videotaping interviews with actors.

> Casey: I thought that we were supposed to do these role-plays with each other before the actress.
>
> Researcher: That's what it had said on the schedule but it just changed a few days ago.
>
> Casey: It would have been easier if we could have practiced on each other.

It would be remiss of me to not mention that some small group role-playing did occur but not in response to the learning request of the student. The students were aware that they would have to be taped during an interview for evaluation purposes but they recognized the lower risk of role-playing with each other before role-playing with the actors.

The students expressed their need to have some control over classroom learning experiences in the backstage arena but were hesitant to articulate these needs in the frontstage setting. The students could be perceived as having little power to change the situation but they did,

however, exert some control over the learning experience by not volunteering to enter the experience with enthusiasm. Many of the students refused to go first when the videotaping sessions began unless requested by the instructor. This group of women did not overtly refuse to participate but covertly expressed their opinion of the experience through their actions of resistance. Foucault (1980) identified that type of resistance as a form of power. He described power as something that circulates - something that is never in owned by particular persons. In any situation individuals both undergo and exercise power.

Being Marked in Class

Although the practice communication sessions were not formally graded in class, the students were aware that the other students and instructors could see and hear what was happening in the taping room and were informally evaluating their conversations according to recommended criteria. They also knew that their performance would eventually be graded by the instructor. The students were concerned that communication became "fake" when they felt obligated to perform according to set criteria.

> I find it's a lot easier to practice with a friend and it's totally different than getting into another room and talking to someone who you know is an actor. You know that she's just making up this story and that there's a classroom watching you. I could sit here in front of you guys, I'd be fine and do a situation but knowing that there's other people out there . . . I feel it's fake (Casey).

Communication is a contextual event. Structuring it to fit criteria takes communication out of context of a person's life and places it in categories without meaning and connectedness to that person. Nursing

education has been, in many instances, developed around a behavioral framework that, according to Pitts (1985), separates students from the knowledge they bring into a situation and the significance of their suggestions for learning. As Belenky, Clinchy, Goldberg, and Tarule (1986) have observed, traditional courses do not begin by asking what women know but with the teacher's knowledge. In this case, students did what the criteria demanded of them while recognizing that they would not implement some of the specific behaviors in practice. Shaking hands, for example, is a white, middle-class, primarily male, socially constructed behavior. Many First Nations groups are uncomfortable with behaviors such as hand-shaking and eye contact and do not respond to the overtures that are considered appropriate in a traditional (white, middle-class) therapeutic interview. Other cultural groups are comfortable with different greetings and communication techniques than what is traditionally taught. The point here is that the behaviors expected from students are socially constructed, and again, context situated. As one student commented:

> I'm not saying that the whole process [videotaping] is bad there are some really great things there, like I never realized that, yes, you should build up to termination to let them know. I'd never thought of that before. But there's just some key things in there that I'm putting in because I have to but it wouldn't be natural (Ellen).

Ultimately though, the power that "the mark" had over students to conform to the curricular agenda held the greatest influence in how much students pressed for change. Many of the students were cognizant of the eventual evaluation of their performance.

> Researcher: Now the grading element . . . are you conscious of that while you're doing the tape?
>
> Ellen: Well, basically, they have to do something. They have to have some method of checking us I guess. Ya, I was surprised at how picky it was, how everything was broken down into steps. Hm, the use of good-bye and what not. No, they don't like to see "see you later". You have to use good-bye. And the handshake, I think that is what I don't like to do, see, I really wouldn't be myself because I have to go through all these little things in my mind to make sure I get them . . . so that's not playing myself.

Ellen knew from her own work experiences with various clients that conducting an interview according to structured criteria was not always appropriate. However, she felt bound by the constraints of the marking guideline to perform according to the curriculum if she were to get an acceptable mark. The use of detailed marking criteria could be a form of "normalizing judgment" as described by Foucault (as cited in Rabinow, 1984). Student behaviors that did not meet the established norms were "punished" by mark deductions. The term "punished" may be a bit harsh but it represents how we, as educators, encourage conformity rather than creativity. As Campbell (1995) noted, when only textually-mediated knowledge (that which is reflected in a marking guide) is accounted for, the diversity of nursing knowledge becomes hidden from view.

In any kind of objectified interview, sensitivity to culture, gender, and other issues are not dealt with in a meaningful manner. It is the frontstage behavior that becomes the textual account of the 'correct' interview rather than the experienced actuality of what occurs during communication with clients. It is not the intent of this analysis to critique the marking criteria itself but to identify the hidden power that

exists in marking criteria to direct student behaviors in a specific social direction. The issue that arises from the data is whether we want nursing students to adopt our definition of 'therapeutic communication' by insisting on specific marking criteria or to encourage students to explore and learn about communication in previously undiscovered way by relinquishing control over the evaluation process.

Not Being Watched and Marked

In some instances there was no requirement of students to give a performance to others. There was no specific test on the content from class, required readings, or on psychomotor skills taught in the lab. It was interesting to note how behaviors changed in students when the power of a grade was removed. It appeared that there was an assumption held by some students that the only significant kind of information to learn is that which is marked or watched.

For example, one expectation of students was to practice lab skills before entering the clinical area. The students had been taught how to measure blood pressure, temperature, and pulse during the previous academic year and were expected to practice these skills in addition to the skills taught during this course. I noticed that no one used the lab practice time allotted in the schedule to any extent. I asked some of the students about this observation.

> We did one little stint at the beginning of the year, temperatures, BP's, pulses and that was it. So if you wanted to use the equipment it was in here but you say to yourself, "I'm not going anywhere, I won't be in the hospital, why bother?", and think of stuff like that to the point where you just didn't do it. So I think that we should have had an hour a week or something, that was structured, with the instructors here because if it is left up to just

> us, most would just say, "see you later". Because if it doesn't need to be done . . . I mean, not all, if it's structured then you have to do it. If you're watched and marked then you'd be more serious at it (Ellen).

> We're not used to being here nine to four at all. We only had to be here for two days during the regular semester and we're all tired. I'm like, I gotta get out of here. It seems like we just start and the sun comes out and so we just want to get outside and I don't know, like, I want to practice my blood pressure and I know that I'm going to leave it until Thursday afternoon [the day before clinical practice] to do it and it's pretty much a given. Not that I want to procrastinate, but I don't know, maybe deep down, I feel that I know it and that I don't really need to go over it again and again? But I want to double check it just once. Or maybe, it's that maybe that if I think I do it on Monday then by Friday I won't remember it anyway. So I don't know which one it would be, cause we haven't done it since first semester (Erna).

While one point to note from these anecdotes was that temperatures, pulses, and blood pressures were not practiced frequently because many of the times for the practice were unstructured and unsupervised, the other point was that, for these students, supervision and evaluation somehow legitimized the importance of the skills that have been taught. The students realized that they would have to learn particular skills to use in the clinical practice area but it was not deemed a priority until there was some kind of evaluation of their ability to perform the skill.

Another example of the change in student behavior with the removal of testing was related to required readings. I observed that very few students entered the library to look at the required readings in the binder. I asked a student to comment on this observation.

> I went through the required readings and I read all the ones that I had questions about and I know that there were a lot of girls who haven't even bothered to look in the binder because, they're, well,

> some of them say that because we're not having a test so, I'm not going to bother trying to learn that stuff (Erna).

Diekelmann (1992) found in her research on the lived experiences of nursing students and teachers that a teacher-centered behavioral approach to learning has an emphasis on testing. Learning in a behavioral curriculum becomes narrowly defined as the retention of facts instead of the search for understanding. Most of the students in this study responded unsurprisingly to the fact that there was no test on the readings or the lab skills by not reading or practicing them.

Being Watched and Marked in the Clinical Area

The impression students have about being watched and marked in the clinical area was of a slightly different nature than in the classroom or lab setting. Most of the participants experienced the sensation that their activities were being monitored to different degrees by the instructor, the RNs on the unit, other health care providers, and to a much lesser degree, by other students.

In contrast to the classroom setting, where the students performed in front of the camera and then became one of the audience, in the clinical setting there was the impression of some that they were frontstage all the time.

> Jane: Today I felt like I just shouldn't be sitting down, [quoting self], "I've got to get out of here because I'm going to get caught sitting down again".
>
> Researcher: Who would you get "caught" by? [pause] You don't know?
>
> Jane: It's just a feeling that I had. Like I should be doing something. You can only walk the halls and check the patients just

> so many times and read the chart. I must have read his chart or read what I knew on it 50 times.

It is an unwritten institutional expectation that nurses are to be busy at all times. This would be an example of Foucault's (as cited in Rabinow, 1984) use of the term panopticism. Although there was no demand by the instructor to be busy all the time, the student's expectation to be so has been constructed through her exposure to the socially legitimized role of the nurse perpetuated by those in authority. Traditionally value has been placed on the physical work of nurses and tangible outcomes (Olsen, 1993), and less value placed on the intangible work of nurses. Physical work and visible productivity still has a very high value in today's hospitals and the value of these activities was communicated even to novice nursing students. Learning in this situation was closely tied to productivity as documented in the following student comment, "I think this clinical is a waste of time because we can't do much . . . I'm not learning anything".

According to some students, the apprehension of being watched varied in intensity depending on the relationship that was established between the student and the person who was watching their activities.

> The first day [of clinical practice] I mentioned that I didn't feel comfortable at all. It was the staff. They didn't want to answer questions, you felt like you were bothering them. They were sharp, said certain comments that you didn't like that you overheard. I didn't like it, but today it was a whole new staff. You could go to anyone of the nurses with a question and you didn't feel like you were stupid or bothering them or anything. It made a big difference. I enjoyed myself much better. I was more comfortable with my patient. For instance, being in the room performing a task with my patient on Friday made me uncomfortable just knowing that **that** nurse was in the room doing something else. Okay? Because what if she's watching?, what if she's looking?, what if

> she's here?. Right? However, today I was in there with my patient doing whatever and they were in and out all day long and it didn't fizz me just because of their attitude and I was more comfortable. It makes a big difference (Ellen).

Although the nurses did not have a formal role in evaluating the care students provided to clients, students were aware that their actions were being watched by nurses. In particular, if nurses somehow indicated that they mistrusted students then the watching behaviors were perceived to be evaluative. Unlike Wilson's (1994) study, which found that students did not perceive staff observations as part of the students' evaluation, the students in this study believed that evaluative observations by nurses could be reflected on their final evaluation by the instructor.

> [I'm careful] even with the RN because we know she's reporting to the instructor and we know that they're talking about us, so you want to do good things around her too and ah, try to make yourself look as good as you can in their eyes because it does come down to the grade (Erna).

An additional component of being watched and marked came into play when the students had to care for patients in the presence of the instructor. The students commented on the trust that they had in their instructors and the reciprocal trust that the instructors had in them but the power of evaluation was sometimes detrimental to the trusting relationship.

> Cindy: I have to give a patient a bed bath and I haven't done it before. I'm afraid that I'm going to move her the wrong way. She's really weak and frail. The instructor is going to be there too, but then again, if I do something wrong she's right there to see it.
>
> Researcher: Is the comfort of having the instructor with you greater than the fear of being evaluated?

Cindy: Not really, but it has to be that way.

The comment "it has to be that way" expressed how this student believed a learning environment had to be constructed. The student-instructor interaction was approached as some form of test rather than as an opportunity to learn. It was only after having the instructor help Cindy with client care that she was able to recognize the role the instructor played in her learning about client care.

This student and other students accepted the clinical evaluation process as given although some students did verbalize backstage that they disagreed with the numerical evaluation of clinical practice. According to these students learning, again, became closely associated with evaluation.

> I keep thinking about the mark and how you have to get an eight out of ten on all your things [objectives]. And the whole time I kept thinking that. The instructor was with me the whole day really, and I kept thinking, you know, I need to get a C on all the stuff here but I don't know how well I'm doing and stuff. The marking scheme really, really, bugs me. Like, how they said, you know, that "you have to get an eight out of ten on everything in order to pass", you know, "it's hard to get a ten out of ten" and that sort of thing really bugs me. I think about it all the time when I'm in there with the patient. I know that probably other people don't feel that way but I do though. All the time I kept thinking, you know, I've got to start smartening up so that, so I can pass. I don't agree with a mark for clinical but I know that I need to get a C and that I don't have time to get As. I mean, I did a lot of stuff but I kept thinking, you know, is it unsatisfactory or is it satisfactory? Is it good or is this excellent or what? The whole time I kept thinking and marking myself in my head and asking questions to myself but yet I kept thinking, well, this is all in a mark. This is marked out of forty, everything I'm doing (Sara).

Most students believed that the quality of the performance they gave would influence the mark they would receive for the clinical

component of the course. This type of linear thinking is common in schools of nursing. It implies that there is an objective way of marking what is subjective in nature. These statements do not intend to imply that the performances by the students were not authentic or genuine, rather, that subsumed in their performance was the awareness that this performance ultimately was going to be evaluated and that they would receive an associated grade.

> It's like when you're with the instructor, you always want to try and impress her. And, even if you're doing something and she comes in and says "how's it going?", even if it's only so-so you go "great!". Because you don't, I mean I have gone to her and said "I just don't know" and I have asked her advice and that's good too because then she doesn't think I'm cocky which would be the wrong direction to take as well. So, I think it's like a teeter-totter there and you know, it's good to let her know that you have questions but it's good to let her know that you've got it under control (Erna).

Diekelmann (1992) observed that when emphasis on evaluation is great it creates problems for both teachers and students. In this study students perceived that they were unable to dialogue freely with the instructors because of their concerns about being evaluated poorly if they were believed to not have specific knowledge. As in Diekelmann's (1992) study, although the students respected the instructors, the behavioral nature of the curriculum perpetuated a relationship in which the teacher was perceived to be in a powerful position in that the student was dependent on the instructor for a passing grade.

Students in the clinical area did not mind being watched by other students. The students actually sought out other students to be with them during certain new experiences as a source of support.

> I think with each other we don't try to impress each other. I just know that she doesn't know any more than I do. So, I don't feel dumb asking her this and I don't have to try and put on a show. I don't have to try and impress her (Erna).

There was no obvious competition between students in the clinical area. Students asked each other questions and worked through problems together when possible. There was a sense that everyone was in the same position ("low") and that they relied on each other to make it through the clinical experience. Fear of failure or looking incompetent resulted in a cooperative spirit among the students who were surrounded by others who had more power than they. The collective became a source of support.

It was interesting to note that students did not express any concerns about their actions being watched by their patients. They talked about how much they learned from their patients but did not express any fears about being evaluated in any way by the patient. The presence of family members while caring for the patient was a little disconcerting to one student initially but she commented that she got used to their presence quickly. The students commented that the patients really enjoyed and appreciated the extra attention that they received from the students and that any pressure they felt about being watched generally came from having the instructor or other nurses present while caring for a patient.

Summary

These students have confirmed what most students would find unsurprising, that a performance is acted out for the benefit of the instructors with a minimum goal of a passing grade. In most instances

the performance is genuine but in other instances the performance is contrived. The more closely behaviors are watched, especially by the instructor, the less natural the performance. The theme of "being watched and marked" describes the power differential between instructors and students that is constructed by a traditional evaluation process. This is not to say that learning did not occur as a result of these performances but learning became so closely associated with evaluation that the two were many times indistinguishable.

The next section will focus on another theme related to learning derived from the ethnographic data. The theme focuses on the backstage process students used to make sense of their learning.

"Going Over Things in My Mind"

One of the aims for this study was to discover how students used their knowledge to inform their behavior in an initial clinical course. I was curious about how they integrated what they heard in class, read, saw, and already knew into their knowledge base. During data analysis it became apparent that this process was a backstage experience. The students sifted through what they heard, saw, and knew and sorted this information into some kind of form that made sense to them. Making sense of learning experiences involved reflecting on those experiences, adapting formal theory to practice, and drawing on personal knowledge and values related to the experience.

Active Reflection

Students reflected on their performances, the performances of others, and on events that occurred throughout the course to help make learning experiences meaningful to them. Interviewing students and

talking to them about their learning experiences became an opportunity for many of the students in the study to reflect on their learning. Whether reflection would have occurred to the same extent without the specific times set aside for the study interviews is unknown. In addition to the interviews students were required, as a journal assignment, to reflect on an event during their first clinical practice day. As it was impossible for me to observe how students used reflection as a source of learning, all the data supporting this sub-theme were extrapolated from interview transcripts, journals, and verbatim accounts of student conversations.

Reflecting on performances was a means for students to reconcile the textbook standard to the reality of practice. Initially, there was a sense that, for some of the students, the ultimate goal of learning was to "get it right" like the book. Underlying many of the students' comments was the dichotomy between the standard of what was "supposed to be done" versus what actually happened. One student related it as such.

> I came into clinical with this big set plan and I was really concerned with having it done just like they had done it in the textbook and I was like, [pause], I soon realized that it wasn't going to happen. Like I wasn't in total control of every situation here. The resident had her plan for what was going to happen and I was expected to do it her way. She knew how she wanted her shower done and when and I had to learn from her what to do. So, um, my first clinical experience was an eye-opener really because, you know, no matter how many times you read something, it's never the same (Erna).

At some point in Erna's education, she learned that if the steps were followed as outlined, the procedure would be performed correctly. But, in fact, this was not the case. Many nursing textbooks reduce

interventions to steps or stages giving students the impression that there are acontextual, essential behaviors that they must engage in to provide client care. I am not disagreeing with the need to provide safe care, rather, I am advocating for the need for teaching contextual nursing care. In the exemplar above, Erna learned very quickly that following the "steps" without considering the context of the client can lead to an unanticipated situation. This student was able to adapt to the situation but sometimes reducing what should be holistic procedures to sequential steps leads students into situations where they are not always able to adapt. Diekelmann (1992) critiqued this lack of consideration for context or situatedness of learning within nursing education. She stated that, without context, learning becomes defined as "the retention and corresponding application of facts" and "what matters, which is thinking in particular situations, becomes lost as students are schooled to enter practice with a corresponding view of applying content (rules) to practice" (p. 247).

Another student described her first clinical experience as such:

> [I met] with the client formally for the first time and began the morning tasks I had set out to do. . . . I wanted to look confident in what I was doing while at the same time trying not to be too overconfident. I wanted to get things started and do what I thought I should have been doing. I rushed myself and forgot about one of the floor's daily routines. I almost started the bed bath too early. I felt that if I had something to do and was doing what I thought I should have been doing my apprehensive feelings would go away. . . . I had to help get the [client] back into the wheel chair and get out of the frame of mind I was in. I had to wait until the [unit] meeting was over, when what I really wanted to do was get going with what I had planned to do . . . . I wanted to do a good job, look professional to the client and try not to be scared about what I was about to do. I was anxious but at the same time confident that I

> could do the tasks that I had set out for myself. I was going over everything in my mind that I should have been doing all at once. My mind was so boggled with so much information that I forgot about what I was supposed to do . . . I believed that the professors expected us to do what was set forth and to excel in what we were to do. Because of all these things I acted before I stopped and thought about what I was doing. I wanted to get things done . . . . I have learned from this experience that I should slow down and take things in stride. In similar situations I will try and tell myself that I can slow down and still seem to others as being confident.

This exemplar describes the difficulty the student had adapting to the change in her plan for the day. She had expectations of her performance that she wanted to meet. For this student looking "professional", "good" or "confident" to both the client and the instructor was important. In fact, of course, a neophyte cannot be expected to be confident in any new task or situation. Wilson (1994) also found that the goal of looking good guided the students behaviors in the clinical area. The students in this and Wilson's study had an image of a standard that they were to meet ("to excel") and the ability to meet or not meet this standard was a reflection of the students' competence. It was difficult for them to reflect on their actions during the performance and adjust their actions according to the context of what was occurring. Learning occurred by reflecting on incidents after they occurred.

Students also reflected on their learning in the journal assignment. For many students, taking an initial clinical course meant that they had to confront their fears and anxieties about becoming a nurse and caring for clients in an intimate fashion as they had not done prior to this point in the program. The fear of washing a client was frequently noted in student journals. As one student wrote in her clinical journal:

> Giving a bed bath was one of my biggest fears and peri-care was my nightmare. My main objective that morning with my patient was to give her a complete bed bath - as we learned in the classroom session. First I closed the curtain, then I proceeded to gather up the necessary supplies, then I got my water ready. When I returned to her bedside with the water she looked up and said, "I'm sure you've seen all this before", as she removed her night gown and sat on the edge of her bed in her underwear. I was quite honestly shocked at her openness. Mostly, I was not expecting her to be so comfortable with me. I reality I was a bit uncomfortable, but I did not let her see my discomfort . . . . As I progressed through the steps of giving a bed bath I realized that there was nothing to be nervous about. She seemed to be at ease . . . . When it came time for her peri-care a wave of anxiety washed over me. I was a bit scared of how she would react and I was a bit shy (after all, if the situations were reversed, I would not like to have my private parts probed). I did, however, manage to finish the peri-care part of her bed bath (although maybe a little too quickly). Nevertheless, she did not seem to mind and again she did not seem uncomfortable. My first bed bath was over. Although I had felt nervous at times during the bath, I felt that it had gone well.

This student used written reflection as a way of learning from incidents. Journal writing has been used fairly extensively in nursing and other health care professions as a means of assisting students to acquire critical thinking skills, integrate and apply knowledge to practice, increase observational skills, explore fears about clinical experiences, and empower individuals (Cameron & Mitchell, 1993; Heinrich, 1992; Tryssenaar, 1995).

Even as I have used the student journals as a source of data, at the same time I have to be aware of the limitations of journal records. An examination of the journals completed by the participants in this study indicated that they reflected on a specific experiences but only according to the questions identified in the assignment outline. Many of the journals became a question-answer session fulfilling the requirements of

the course. This is not to say that the experiences the students wrote about were not critical to their learning, but the lived experience was noticeably reduced to a quantifiable record structured to meet the assignment criteria. Journals are supposed to be, according to Cameron and Mitchell (1993), a shared experience between students and faculty but can easily become an account of what students think teachers want to hear. Journals should be a safe place to explore learning experiences (Diekelmann, 1990) but, as soon as a mark value (especially when not determined by the student) is placed on the journal, the construction of what students write and for whom comes into question. As one student said about the journal assignment, "it's called b. s., I'm good with it". The combination of the perceived need to meet set criteria and the limitation of the journal to one entry restricted, but did not exclude, the usefulness of writing a journal as a means of learning through self-reflection.

Students reflected on, and tried to make sense of, what they saw and heard about in the course. In some instances they were able to easily see the relevance of what they saw and heard in class, lab, and particularly in clinical practice but other times they questioned the construction of certain learning activities. For example, prior to starting the clinical practice component of the course the students watched a video of a nurse performing a bed bath. The video showed an elderly mobile white man being washed in bed by a female white nurse. He was able to lift his arms and turn independently throughout the bath. After the tape was over I talked to the students about what they saw. The students reflected on the need for the nurse to be so methodical during the bath.

> Do you really have to be that meticulous? Why should you have to wash someone that way when they normally wouldn't wash themselves that way. Who are the type of people who need a bed bath anyway? (Ellen).

As educators, we many times continue to prepare students for clinical situations in an unrealistic manner, not exploring the context of client situations with students. There was no indication on the tape of what to do if clients are incontinent or have specific religious beliefs that direct how nursing care should be delivered. One student reflected on the acontextual nature of the bed bath video one day after clinical practice.

> Researcher: Did the classroom and videos help you prepare for clinical?
>
> Erna: Well [pause] a bit but it's not like real life - it's fake. This is real. Like we watched the video about a bed bath but it's nothing like that. They guy in the video would lift up his arm, anyone who's getting a bed bath can't do that. The classroom stuff helps you prepare a bit but this is where I really learned how to care for people.

This student did not dismiss the relevance of preparatory information but noted that the "fake" nature of the information as not being practical.

As a feminist doing this study, I previously noted how important it was to confirm themes with the students. The students expressed the importance of clinical learning experiences in all themes derived from the data. They were adamant that it was in clinical practice where the greatest learning occurred. Students stressed that clinical learning did not only include how to care for patients, as noted in the exemplar above, but what they learned about themselves and their capabilities as well. One student reflected on the changes she had noticed in herself toward the end of the clinical component of the course.

> Ellen: Anybody can learn a skill but there's . . . in this there's a lot of listening and I just find now, before it was like you jump into a problem and you solve it. Now I'm kind of taking a step back and soaking everything in which isn't usually like me. Usually I'm like this and looking for a solution. Now, I'm just kinda stepping back and taking all the information in and just nodding and listening and being there. So that's different. Man, that's a lot when you think of it. It is for me because, see, I'm just used to barreling right into something and attacking it.
>
> Researcher: Did you notice this change within this clinical course?
>
> Ellen: Yes, just this clinical. Not even the classroom. Because you probably notice that in the classroom I'm forthcoming with knowledge and questions, it's just these last two days.

Students also reflected on the actions of others as a means of learning. The most significant role-models were nursing instructors. Role-modeling has been noted to be a source for learning nursing in a number of other studies (Campbell et al., 1994; Davies, 1993; duToit, 1995). Most of the incidents where learning from the actions of instructors occurred were in the clinical area.

> I kept thinking, well I have to use empathy. I knew when she [the client] was crying, the instructor used a lot of empathy and then I felt more comfortable using it. At first I didn't know when she was crying to say there "I know you're upset" but I kept I feeling like I should be telling her about how I feel about it. But then I started using it [empathy], once I saw someone else using it, like the instructor was using it. "Well, you're really upset and I can see that and I know that this has got to be a difficult time for you" and that sort of thing then it was easier to do (Sara).

Not all learning from the actions of others occurred in a positive manner. Students were aware when the actions of other nurses were not congruent with their expectations of the helping role of the nurse.

> Jane: The one thing I don't like is if you asked one nurse and he's [the patient's] not on her team, "Oh, that's not my patient". It's like,

somebody please help this person. This one individual needed his oxygen turned off. I know how to do it but I can't do it so I have to find somebody and she goes, "that's not my patient, it's so and so's patient" and so I looked and looked and looked for this person.

Sara: It's just like there was this one man who was throwing up and one of his roommates came out into the hallway and another student said "Can you come with me?", but at that time my patient was throwing up too. So the instructor went in and was doing . . . like it wasn't one of our patients but she was helping out but we didn't see any of the other nurses around helping out.

Jane: They have a lot of paperwork and stuff that they have to do too.

Sara: I understand that there's a lot of other things to do too.

Researcher: But there's a difference? I mean just from what you said, there's a difference between the way the instructor approached patient care and the way the other nurses did?

Jane: I think that maybe it's to do with the degree of education that she has too. There's a lot more focus on communication skills and stuff and they have a lot more focus on basic skills.

Sara: But also I think it's maybe they've done the same thing every single day and maybe they're getting tired of it whereas our instructor isn't burned out and she's right there willing to help and she wants . . . she's trying to show us that it's all right. Do you know what I mean? It's all right to go out and help other patients and she's trying to show us that . . . I see that as that I can help out anybody.

Researcher: And that's learning? You learn from having a good role model?

Sara: Oh, ya.

In this situation the two students were able to reflect on the negative behavior of the nurses and compare it to the positive behavior of the clinical instructor. The evaluative role of the instructor was replaced with a learner-centered interaction that positively affected student

learning. It would have been easy to leave the analysis at this point but these students were exposed to a situation that taught them about some of the values nurses hold about practice and the construction of the role of nurses. Nurses are potentially powerful role models in the professional socialization process students (Davies, 1993). Andersson (1993) found that students' understanding of the professional role of the nurse is derived from what they have actually seen nurses do. In this study it meant that tasks related to specific client assignments, rather than helping activities, were associated with professional role-identity. The students saw what the nurses did and did not do but developed excuses for the nurses' behavior as they appeared to be unwilling to believe that these nurses did not value client care in the same manner as they.

In summary, students used reflection as a means of sorting and making sense of their learning experiences. It was a process of learning from their own, and others' performances. Through the use of reflection, the students began to develop a beginning notion of who they are as nurses and what their role will be in relation to client care. Their emphasis on clinical practice as a means of valuable learning was of primary importance.

In the next sub-theme I will analyze how students, after they have reflected on what they saw, heard, and experienced in nursing education, adapted the information or theory to make sense of it and thus integrated it into their learning.

"Adapting": Learning to Be Flexible

"Transfer of learning is a fundamental assumption of all education since there is little point in learning something unless it will be

remember and used in some way in the future" (Cooke, 1993, p. 1992). But how do students go about transferring that learning so it has meaning for them? As noted in the theme "being watched and marked", students will artificially provide evidence that learning has occurred if their performance is being marked. Therefore learning and the transfer of learning is not as simple as instructors watching and measuring behavior to verify that learning has occurred. To address this issue during the study, I asked students the question, "How do you go about transferring what you learned in this course into your nursing practice?". Many of the students referred to knowledge transfer as an adaptation process.

> A lot of it [theory] had to be adapted. Because in the classroom you learn roundabout points of everything. But, everything doesn't suit everybody. So, with my client I was discovering that a lot of things that Erickson had described as psychosocial, just weren't happening. It didn't even apply. So I had to rethink it and I kinda had to like in my mind, think about what he had said, knock out stuff that didn't apply and try to expand on the stuff that did to get some more info. And communication skills had to be adjusted per person even, like, between my client and then the client down the hall because my client is very alert and very interactive where with the client down the hall you had to speak very slowly and very loud and very basically. I was adapting from room to room (Erna).

> I didn't think "Gazda says you gotta do this and you gotta do that" . . . I never thought of that at all. I said what I thought was comfortable. I did what I thought was comfortable. I mean when they were saying earlier, about that patient who just had a stroke, and another student said, "just use empathy". I don't think empathy would have been appropriate at that time because she just had a stroke, she's not feeling well. You've gotta let her have time to think it through herself before you start boggling her with all these questions and getting her mind all . . . I just did what I thought was best for the patient. . But you had . . . ya some of it's good, warmth, you know. I think a lot of it is common sense. Like, I

> mean, you base it on something but you don't use exactly what they say. I mean, you adapt it to the situation (Casey).

The students took a "common sense" approach to applying theory to practice. They created their own beginning theory about what worked and what did not in clinical practice. Casey identified that her understanding of empathy did not fit the clinical situation so she used warmth instead. In this case, the definition of empathy had been constructed to such a degree for these students that it is referred to as almost a commodity that nurses can be apply to any given situation. Burnard (1992b) stated that his research indicated that empathy is a loosely defined term that has different meanings for different people and that its requirement in a therapeutic relationship can be argued.

Students, as noted, used the term "common sense" to describe situations where intuitive knowledge informed their practice. Intuition is a part of the pattern of knowing Carper (1978) called personal knowledge. There was a beginning "sense" of the other or an "interpersonal connection" (Agan, 1987, p. 66) that helped students adapt theory to their practice.

In nursing, there continues to be an ongoing debate about the theory-practice gap (Wilson-Thomas, 1995). This gap signifies, for some, the difficulty nurses face applying theory to the realities of practice. Cooke (1993) suggested that the theory-practice gap "reflects a conflict of ideas which arises from the differing class positions of those in education and practice" (p. 1995). Porter and Ryan (1996) argued that the theory-practice gap is largely generated by, neither the lack of knowledge that nurses have, class conflict, nor antipathy toward theory, but rather organizational constraints and the fiscal crises in health care prohibits

nurses from implementing theory. I would question the nurses and researchers who identify a theory-practice gap about their definition of "theory" and whether they perceive adapting theory to practice as not using theory in practice. Lauder (1996) argued against the structuralist notion that all nursing knowledge must be placed in the context of nursing theory. He suggested that students construct their own alternative theoretical frameworks. The students in this study, even in the beginning stages of nursing education, recognized and adapted what was presented to them in class/theory to practice. They were able to identify the contextual nature of clinical practice as grounds to modify theory. In short, they became flexible and open to different situations.

For most, though, it took "hands on" clinical practice to make meaningful the knowledge they had acquired in theory. Even at a beginning level these students were able to recognize how affirming clinical practice was to their learning.

> Researcher: What was most helpful to your learning so far?
>
> Ellen: The actual doing. The actual doing, which surprised me because I'm more of a book person. BUT, books and stuff are okay for skills because there's a procedure and there's step by step but when you get into communication with your patient there's no book that's going to say "Well, this patient is going to say this and this is how you're going to react". So, for the communication part of it, it wasn't until you're actually doing, right, the steps or the model with the patient . . . . The real world is more important, what you do in the real world, you have to adapt quickly - you don't fight with yourself, about what you've learned - just do what's best for the patient. You can reflect on it after.

Schön (1987) argued that in a normative curriculum where a practicum comes last, the traditional view of technical or "professional" knowledge

is valued higher than practical knowledge. This is not to say that students should be placed in practice situations without any exposure to theoretical knowledge but to recognize that, at least for these students, theory became more meaningful with practice. Nelms (1990) recommended that nursing education transcend "our old beliefs about how persons come to possess knowledge and conceiving new modes of nursing curricula that enhance the kinds of knowledge acquired through clinical practice and clinical praxis" (p. 290). It was these students' experience that clinical practice made the greatest difference to their educational aims.

> We know we want to be nurses now. I think it gives you more of the, "Is this what I want to do? Can I handle it?" stuff. It makes you decide if you should come back next year. I think, I mean, if you don't like clinical, you're not going to like being a nurse very much (Casey).

Drawing on Personal Knowledge

For the most part, the students in this study did not have a great deal of experience caring for people in a nursing role. Many of the components of the course involved students being placed in situations where they had little prior experience. Therefore, to make sense of and sort through what they saw and heard in the course, students drew on their own experiences in the world, integrated what learned from the experiences of others, and identified their values and beliefs to understand themselves in the context of the role of the nurse.

Although the students had minimal experience being nurses, they had a vast collective experience of being students. As I talked to the students about their learning experiences they frequently drew on the

knowledge they had acquired in other areas of their lives to help them understand new concepts. In a discussion between two students on the value of taped communication practice sessions to their learning, Sara used her experience in group work to justify the purpose of the practice times.

> Didn't you ever hear of group work? Three heads are better than one? I know the group work and we've done group work. We've done a little bit of group work and we've done a little bit of individual work but I find that if I write a paper, my paper can only be as good as I can do it. But if I write a paper and I get you to critique it then it's as good as both of our heads. Then if I get her [the teacher] to correct it, then it's as good as all three of us . . . . It's called, practice makes perfect and the only way you're going to get better is if you practice your skills or you practice your communication skills.

Casey, the student who was in the discussion with Sara, disagreed with the usefulness of the practice sessions to her learning. She was able to recognize from her experience that, although it was a means of learning for some, "it's not the only way to learn". It was obvious from the discussion between these two students and during other discussions that for learning to occur in a meaningful way, teaching approaches need to be less structured and more open to suggestions generated from the students' experiences. In a situation that involves obvious self-confrontation, such as being videotaped, the experience can actually be detrimental to learning for some students (Finley et al., 1979). As Bevis (1990) states, "flexibility may be one of the most ignored of one's important personal assets" (p. 102).

All students bring subjective knowledge with them into a learning environment. As Boggs (1981) says, "adults do not lack an experiential

base; their need is to make sense of the experiences that bombard them" (p. 5). Hedin and Donovan (1989) advocate for a nursing education that is based on feminist values. By this, in part, they mean that education should be empowering to students. "Students are empowered as they come to accept that they have answers and/or are capable of discovering them, and that they do not need to wait for others to tell them what to do and how to think" (p. 9). Students in this study did not dismiss learning activities as non-meaningful to all but sought some control in how they approached the experience based on the knowledge they have about themselves and how they go about learning.

As well, hearing about the experiences of others and blending that knowledge into their knowledge base was identified as beneficial by students. In response to the question, "What helps you learn in class?", these students replied as such:

> A lot of feedback from students. There will be a topic we're discussing and, hm, everybody has experiences of some kind that relate to what we're talking about and everybody likes to get in their story or what happened to them or whatever. So you learn a lot, not just from the instructors but from your classmates because they're willing to talk and I think it's because of that closeness. I mean, I can't see, you know, somebody offering one of their past experiences in the hospital in front of a lecture of fifty or sixty people (Ellen).

> But, um, another thing about the classroom is that we're small, a small group, and we can relate to personal experiences and, like you say, we're talking about whether you have ever been in a conversation where nonverbal cues have not matched the verbal and we got to tell examples and in a big class you can't do that. Like you just don't have the time and I think that makes a big difference for us and it makes a big difference for me, anyway, because we can relate it to stuff and you have time to sit there and

> think about it. The professor isn't rushing on to the next topic. So, I think that helps a lot (Erna).

Similar to findings in Belenky et al.'s (1987) study about women's ways of knowing, these students relied on a mix of received and subjective knowing for some of the answers they needed. Received knowledge, according to Belenky et al., comes from listening to friends as well as authorities. Subjective knowledge comes from listening to one's inner voice for answers.

It was the small size of the class, according to Erna and Ellen, that fostered the closeness and safe space for these students to share their experiences and provided an opportunity to reflect on what had been said. Traditional lecture theaters are not conducive to such sharing. As Erna stated, "I've been in both situations, I've been in the large theater with 150 students and I'd never want to be there again now that I've been here". In many nursing programs there are so many students in a class that students remain "passive recipients of a multitude of facts" (Hedin & Donovan, 1989, p. 9). As one student stated, "you can be invisible in a large class and you never have to speak up or share anything if you don't want to". Freire (1970) analyzed the traditional teacher-student relationship and developed the banking concept of education as a model to describe the dichotomy between human beings and the world in an oppressed environment.

> In the banking concept of education, knowledge is a gift bestowed by those who consider themselves knowledgeable upon those whom they consider to know nothing. Projecting an absolute ignorance onto others, a characteristic of the ideology of

> oppression, negates education and knowledge as a process of inquiry. (p. 53)

Another means of learning by drawing on personal knowledge was related to clinical practice. All of the students commented on how they learned about themselves in the clinical area. Students were able to bring into clinical practice previous personal experiences with ill family members and friends to help them sort through and make sense of the care they were expected to provide to clients. For some, their previous experiences were negative and they were challenged to reconceptualize their ideas about what it meant to care for a person in an institutional environment. The initial clinical experience helped them challenge the values and beliefs they held about themselves in the context of the role of the nurse. Olsson and Gullberg (1987) referred to this concept as "role-conception".

> A conception about something is dependent upon the knowledge, information, attitudes, and norms, etc. held by a person. Change either in a phenomenon or in a context creates a new perspective for this person; that is, he [sic] comes to possess a new conception. (p. 175)

Ellen was able to identify and comment on how her values and beliefs affected her clinical practice.

> The only problem that I have in my clinical is that I feel helpless. Ya, I feel helpless . . . . It's just that I can't seem to do enough. You know, here's an eighty-nine year old lady that, ah, her activity level has decreased dramatically and she's not exactly thrilled about it and I can't do anything for her. I'm sure I know, I know, I can be with her and listen and empathy, respect, warmth, but I can't DO anything for her to make it better. That bugs me. I can't make it go

> away. And that's where they would say, "You're being there, you're listening". I know, but there's that little part of me that likes to fix the problem and I can't do that. I'm beginning to see that I'm not going to be able to do that most of the time and I'm having a little problem with that . . . . And pity. I felt pity for her and I didn't like myself having that feeling because if it was me I wouldn't want anyone to pity me. Nobody likes to be pitied. And I had pity for her and I was almost embarrassed to even put it down [in the journal] and I thought, you shouldn't have pity. Like, you know, I don't know, it's just seems like [pause] not a nursing emotion for one thing, you shouldn't have pity. So I had to deal with that. I had to deal with the pity part of it. I see, I don't want to grow old and I don't look forward to it. And when I see her lying there and know that it's going to be me someday and she can't do what she wants to do and she's active and I felt pity (Ellen).
>
> (A few days later we talked about this issue again.)
>
> You know those feelings of pity I was feeling, well, they're gone. I really got to know this patient and she has had a wonderful life and isn't upset at the change. I think that part of my problem was only seeing old sick people in the hospital as a lab tech. I would come in and take their blood and the skin on their arms would be loose and flabby. They were never really people to me. Now that I've come to know this patient I can get past the pity and really see that what I'm doing is helping her. Ya, I really don't pity her any more.

Ellen entered this clinical situation with a medicocentric reference point. She had been influenced by the expectations of society for nurses to assist in curing those who are ill or at least make their life better in some measurable way. The physician-oriented value of curing as greater than that of caring was apparent initially. The clinical situation she faced challenged her to look at the values and beliefs she held about the elderly as well as the assumptions she held about the role of the nurse before entering the clinical environment and change occurred as a result.

Summary

The backstage experience of learning by going over things in one's mind was a process of making a connection between learning experiences and their meaning to the student. Sometimes learning was a consequence of actively reflecting on actions or observations but other times it was a less intentional questioning process. Students made comparisons between what they heard and saw in class and the practical reality of implementing this knowledge, then they adapted the knowledge as a means of constructing their own understanding of nursing. The clinical practice time in particular was identified by the students as most helpful to their learning. It challenged students' prior assumptions about the nursing role and encouraged them to reflect on their values and beliefs. Backstage learning was not an linear process. The degree to which students were able to reflect, adapt, and draw on personal knowledge varied. For most, the course was very helpful to their learning and it provided an opportunity for students to determine if their choice of entering a nursing program was the right one.

Searching for "Comfort"

For many nursing students in this study, an initial clinical course was the first time they were exposed to "real nursing". Many experiences were new and understandably uncomfortable. This theme is an analysis of their search for "comfort". The theme acts as an umbrella over the other themes analyzed so far in the analysis. In the frontstage experience of "being watched and marked" students generally experienced discomfort or unease with the evaluation process. In the theme, "going over things in my mind", students sorted and sifted through information

in the backstage search for what was comfortable for them to use in practice. In this theme the conditions for learning will be analyzed.

For these participants, the level of comfort for learning constantly changed according to the environment and the level of support from those in that environment. Although it would be easy to interpret "comfort" as confidence, the students did not always equate feeling comfortable or uncomfortable with feeling confident or unconfident. Students felt, unsurprisingly, less confident in new situations but this situation was maximized or minimized by the level of comfort they sensed in the environment around them. Various degrees of comfort were also obtained from experiential learning activities such as doing assignments, watching procedures, and providing client care. The students used these experiences to try to gain insight into the meaning the activities had for the client and themselves. As well, while students searched for comfort there were negative and positive experiences that provided context for learning. Thus, the term "comfort" became fluid in nature rather static or predictable. The following sub-themes will explore the components of comfort within students' lived experience of learning in an initial clinical course.

Comfort and Support

Students experienced different levels of comfort within various learning environments. The classroom environment was the most comfortable place to learn because of its familiarity but even that place became uncomfortable when the learning activity involved a high degree of risk. The locations of the clinical practice components of the course were the most unfamiliar environments to the students but became the

"best" place to learn once they became more comfortable in that environment. However, it became evident in the study that it was not the physical environment that had the greatest influence on their learning but the comfort they derived from the people within the environment.

These students derived greatest comfort from being a part of the student team. Goffman (1959) described a team as a group of people who "are held together by a bond no member of the audience shares" (p. 104). He proceeded to define a team as "a set of individuals whose intimate co-operation is required if a given projected definition of the situation is to be maintained" (p. 104). Goffman's metaphor can be used to describe how people support each other to project an image to the audience. In this case, the team of actors were the students and the audience was comprised mostly of instructors, institutional staff, and clients.

For the students in this study, it was important that they projected an image of being comfortable, or at least not "looking stupid", in front of others. To achieve a sense of frontstage comfort, the students supported each other through a series of activities. Some of the supportive activities occurred in the formal teaching setting and others in the backstage setting. During frontstage activities in class students supported each other through sharing experiences, giving non-judgmental feedback, and providing encouragement. The students willingly shared their positive and negative stories about communicating with health care providers and gave hints to each other about how to approach the client scenarios before entering the taping room. After the student was done taping and the tape was replayed for the class, the students did not make judgmental comments about the tape. The critiques they made of the

tapes were gentle and prefaced with phrases such as, "I don't want to pick it apart but . . .". Other times the students in the group would compliment the students on their performances. The students worked together to make each other look as good as possible in front of the instructor and each other.

There was, however, a sense of awkwardness from the students when they critiqued the tapes. The team support in the classroom was less evident. The students noted that critique of the taped interviews was done mostly by the instructor. These nursing students have rarely critiqued each other's work formally and it was an uncomfortable experience. It was even uncomfortable for students to watch each other students on tape. One student made this comment.

> It made me more nervous. It just made you feel like, I don't want to do that now. It helped in a way because when they were getting critiqued you'd remember, okay, now I know that's what I have to do, that's what I have to say. I don't know, it's still scary (Casey).

For the most part, student support was more evident in the backstage setting. For example, students arranged times to practice communication skills and supported each other during the sessions. During one particular practice session, students shared tips on how to conduct an interview and then, during the interview, gave each other hints about what to say. The students also came out of their roles and talked to each other about how to facilitate conversation. They shared their personal experiences about what someone had said to them that made them feel better. The purpose of the practice, according to the students, was to become more comfortable talking to actor/clients during the videotaping sessions.

Students also supported each other by providing insider information about learning activities. For example, one student from the group just finishing the videotaping session quickly rushed to the waiting students and whispered "the problem with the client is that she's pregnant!". Additional information gave the students more control over what was going to happen in the video session. Melia (1982) developed a category from the data in her study called "nursing in the dark" that described a situation similar to which the students in this study experienced. Melia's analysis addressed the lack of information students were given about clients in the clinical area. The students complained that they were "often left short of information about patients" (p. 331). In both this and Melia's study, the students felt as if they were left in an awkward position because they did not know enough about the client to feel competent entering into the situation. By withholding knowledge from the students (whether unintentionally or intentionally) about the client's situation, power over the student was maintained. The students knew that there was "something wrong" with the client and it was their job to pull it out by using the correct communication techniques, even though they usually had no idea about the problem. This situation left the students feeling quite powerless and hesitant to enter another similar situation. By letting the students in on the problem, the outgoing team members provided knowledge and subsequently power to the in going team members to look good in front of the instructor and students. Ellen summed up the students' supportive relationship as such:

> I have to say that we're a pretty supportive bunch. Class or hospital setting. You know if someone wants us over there to

> ambulate a patient, we're there. In class, if someone's having a problem understanding the concept, we're there. Um, we've had little groups that get together even before a test or an exam and go over the material. You know, Emily was calling me over the weekend about this journal. I went through almost every question with her. I come up with a different idea. You know, it totally changed her mind. She was doing this other experience and I said "did you think about this?" because I knew what she had gone through. She said, "Ya!!". We're very supportive (Ellen).

Students also perceived instructors as source of support. The students referred to the supportive role of the instructor more frequently in their conversations about clinical practice.

> Talking to the instructor mostly [was helpful to learning]. She was there through the whole process [of caring for the client] and she knew what was going on. She talked to the family. So talking to the instructor helped me out a lot. She's very understanding (Sara).

> Very supportive. She there for you. She doesn't make you feel like we're asking stupid things. She's just there (Jane).

There is an abundance of literature that measures or identifies the characteristics of clinical instructors that are perceived to be most effective in fostering student learning (Brown, 1981; Bergman & Gaitskill, 1990; Kirschling et al., 1995; Krichbaum, 1994; Knox & Morgan, 1985; Nehring, 1990). For the students in this study, positive personal characteristics of the instructor and effective interpersonal relationships with students facilitated the sense of support they received from the instructors.

Although the students sought and received support from instructors, it was to a small degree in the overall experience of the course, unlike the research literature in nursing education which is heavily weighted issues addressing instructors' teaching methods or effectiveness. By using an ethnographic method for research, it became

clear how much students must rely on their own resources to find answers to their questions. For example, students were hesitant to interrupt an instructor when she was in a client's room with another student and therefore, tried to seek out assistance from other students before resorting to interrupting the instructor. Unfortunately, there were many times their questions were not answered. I asked one student about getting questions answered in clinical practice.

> Researcher: What do you think you would do if I weren't here to answer your questions?
>
> Jane: Just wonder probably. Maybe look it up in the book or something but I know that I wouldn't have asked the other nurses because they're so busy.

Jane's comment raised concerns about the support available to students in the clinical area. First, she was hesitant to ask for help from staff nurses who are the experts in the clinical area, and second, in response to her comment about looking up information in a book, I later looked around the unit for books and found there was a lack of educational resources on the unit to answer student questions.

Jane's experience of being hesitant to ask for assistance from staff must be placed in context. Sometimes the students did not have any difficulty asking for assistance and their requests were met positively and the result was positive for the students' learning. Other times students had a negative experience with staff that reduced the potential for their learning in that environment. One student described the differences in staff support in an interview as such:

> Researcher: You mentioned before about feeling like you were a burden or in the way or whatever. How were those feelings today?

Ellen: It was good. There were more of us [on the unit] today but I didn't feel in the way half as much. And I think it just has to do with this setting. They [the nurses] were talkative. When somebody is standing there and they don't want to talk to you and their back's turned to you and they're humphing and going on, you think, "Oh, no. I don't want to be here, I must be bothering them". But today they were more receptive. They talked, they joked. I felt welcomed.

Researcher: Did you still feel at all that you were in the way or a burden?

Ellen: No. I can honestly say, not today. Now, at least, I feel comfortable going to them with my questions.

Researcher: So the atmosphere itself was more conducive to learning?

Ellen: Yes. Definitely. But you've got to have had that atmosphere in order to be forthcoming with your questions. Right? Otherwise, it just gets worse. You want to ask your question but you don't want to. Then you don't find out the answer and you feel really bad and it just builds and builds and gets worse.

Researcher: Is there an element of you going about learning how not to be a bother or feeling you're not in the way?

Ellen: It really has to come back to the staff. There's really nothing that I can do to make them accept me. You know, except not to be a pain in the butt or something like that. But it depends on their attitude and then I can slip right in there easy. Do you know what I mean?

Researcher: I think so. It sounds like you're hesitant to ask the first question but once you get a positive response to the first question it just flows from there.

Ellen: Exactly. It does. It goes back to them. So, if they only knew, I'm sure they don't even know or realize the part they have in this.

Other nursing education researchers have written about the influence of the staff on student learning. Windsor (1987) found that the

students' feelings about the staff changed from the first to the last clinical course. She stated "that at first the students tended to fear the nurses and felt ignorant in comparison to them [but] . . . as their interaction with the staff nurses increased their fear of the staff nurses decreased" (p. 153). Wilson (1994) identified that the students' sense of confidence was influenced by feedback from the staff. "When the staff accepted the students' presence, helped them willingly, and made them feel like a part of the health team, the students' sense of confidence increased" (p. 84). Students in Nelms' (1990) phenomenological study greatly valued support received from staff nurses and faculty but were surprised at how little these two groups identified with the lived experience of being a student as they were all students at one time.

The seemingly inconsistent behavior of nurses to support the learning needs of students hints at unacknowledged power relations constructed in the health care environment. Thompson (1987) argued that nurses must acknowledge the existence of domination and power relations within organizational hierarchy. In a sense it would be easy to dismiss this one episode of non-supportive behavior from nurses as insignificant because the students had no complaints about the staff during the remainder of the course but the reality of what happened was not unique. It is not my intention to blame the nurses for their behavior but to place it in the context of the patriarchal influence on the nursing profession. Dickson (1993) contended that, historically, by following a male professional ideology, which is embedded in the belief and value of scientific methods, technical rationality, and the reluctance to trust feminine values of communication and dialogue, the nursing profession

became fragmented. By not helping and not encouraging students to learn, these nurses bought into the artificially constructed power differential between practitioner and student. Thompson encouraged nurses to look beyond these divisions and stated that

> the strength of women's reality can be that it resists power struggles and rests on the power of connections and open communication . . . [and] the commitment to ongoing dialogue and mutual respect is then critical to the social institution of nursing. (pp. 36-37)

The scope of this research did not extend to questioning the nurses about their actions but addressed the negative effect their actions had on the level of comfort for learning students had in that environment. The students were not comfortable asking the nurses questions or getting assistance from them because they were made to feel "belittled", "stupid", and "in the way". As one student stated, "I'd only ask those nurses life or death questions". Thompson (1987) also recognized the destructiveness of divisiveness in nursing. The students in this study have already attributed for some of the division in nursing along educational lines.

> Lots of people still think that the BScN program isn't as good as the diploma program. My friend said that because she has a diploma that she'll be the better nurse (Casey).

> Even one of the psychiatry nurses who was in one [BScN] class this year said that the diploma program was better than the science program because the diploma program had more practical time. She's not in psychiatry now but in some other job and when the issue about diploma versus degree came up, I got the impression she still didn't think much about the degree program (Sara).

In Skillings' (1992) account of a naturalistic study on nurses and horizontal violence, nurses believed that fragmentation in nursing occurred in part because of educational differences or nursing specialties. It is this fragmentation that can lead to horizontal violence. Dickson (1993) attributed the "tensions" and "lack of unity" among the nursing "elite" and hospital-based nurses to the different values held by these groups (p. 82). She suggested that "the adherence of early nursing leaders to the socially successful, available, medical, male-oriented professional ideology has left its imprint on nursing and nursing education" (p. 81). Nursing is experiencing interorganizational conflict, according to Coburn (1988), because of the tension between diploma and degree nurses and the competition between associations, unions, and colleges for nursing loyalty. It was evident that students, even in the first year of a baccalaureate program, were aware of constructed educational divisions between baccalaureate and diploma prepared nurses.

A second concern that arose from the data about getting questions answered was the lack of learning resources on the clinical units where the students cared for clients. Because there were few texts to use as resources, the students relied on the support of instructors and staff to help answer their questions. Normally, many of the students derived comfort from reading about procedures and diagnoses in textbooks or reference material.

> Researcher: During the last couple of days what sources of information did you use to help you prepare for this experience so far?
>
> Ellen: Um, I went to, um, my nursing books for diagnoses. I got out my medical dictionary and I don't even know, I've got so many

> medical books from other areas, I went to them for my diagnosis. And not just for that, but to read up more on it and what they [clients] are like, and stuff like that, with an MI.
>
> Researcher: Were there any sources you used within the hospital as well, on the unit?
>
> Ellen: I went to the charts. I went to the person's personal charts to look up information on them. And, ah, it seems to me that's all. I didn't use any other type of resources at the hospital.

Although the students did not seem aware of the absence of library resources on the unit, the ability for students to engage in self-directed learning was minimal. It is not for me to speculate on the reasons for the absence of library resources on the units but the message in their absence alludes to the amount of value placed on research-based educational material for nurses (and other health care professionals). A responsibility of nursing education is to encourage students to be self-directed in their learning, which in turn creates self-directed nurses, but the resources must be available for this to occur.

Experiential Learning and Comfort

There are two general types of learning. First, tasks of memorizing that have no meaning, are not easy to learn, and likely to be forgotten, or second, significant meaningful experiential learning (Rogers, 1969). Rogers described experiential learning as pervasive learning or learning that makes a difference in behavior, attitudes, and perhaps the personality of the learner. For the students in this study, the opportunity to care for clients in a clinical setting particularly increased their comfort in both beginning to understand their role in the care of clients as well in the 'doing' of nursing. Varying degrees of meaning were attached to other

experiential activities within the course according to the clarity of purposes for the experiences.

As mentioned previously, the focus of the initial clinical course was to promote beginning knowledge and skills for nursing practice with a particular emphasis on communication skills and the helping relationship. However, it was not until they were in "real life" situations did the students describe an increase in comfort with their role in the helping relationship. One student related this incident at the end of the first clinical practice day:

> I still can't put myself in the situation where she [the client] is, so that's really hard too 'cause I've never been in a situation where anyone close to me is dying. That's really hard too, but I know that if I felt all alone which I felt, not in that sense, but you know what I mean, felt all alone then I'd want someone to hold my hand, so I held her hand, and I told her that she didn't have do anything that she didn't want to do. And, just, even when I was washing her and the door was closed and stuff, I still covered her up and I still, even when I put the bedpan on I still put a blanket over top of her for dignity and pride. I know what it's like to be somewhere and want your privacy. And even if, even to me when I washed her and stuff, I still didn't want her to feel uncomfortable . . . It's about trust too because when I was giving her [the client] a full bedbath, she trusted me and she was, like I mean, she trusted me even though I didn't give her a bed pan right the first two or three times and I got help and she trusted that I would get her help when I needed and she trusted me (Sara).

Sara's description of how she cared for her client was a poignant example of how she learned about the qualities of empathy, warmth, and trust from experience. Burnard (1986) recommended both "learning through" experiences (e. g. being washed by another student) and "learning from" experiences (as in the exemplar above) as powerful methods of understanding nursing care but, for many of these students,

the preparatory exercises in class were just a "rehearsal" for clinical practice. MacLeod (1995) and Burnard (1992b) also found that the students in their studies particularly associated learning with the parts of the course that involved dialogue with nurses, patients, and others in practice settings.

Other students derived a great of comfort from watching procedures being done on the unit. At times, seeing and doing tasks became somewhat synonymous with learning.

> I found I learned a lot today. Catheterization and the dressings. Like we had opened up catheter tray but I had never seen the inside of a dressing one. So she showed me, and showed me how you do it. So even before we asked the patient, when we were in the clean utility, she opened it and she put saline in the little thing and said this is this and this is this just in case I couldn't go in at least I saw that part. And she showed me how to put on sterile gloves and stuff . I got to see sterile gloves twice today (Casey).

Infante (1985) emphasized that the focus of "the clinical laboratory should not be on how to care, but on how to apply knowledge to care for clients" (p. 30). However, it was understandable that seeing procedures increased student comfort on the unit. In fact, this student did go and watch the dressing change but, rather than being a passive observer, she talked to the client about the experience of having her dressing changed taking the experience beyond task-centered learning to a client-focused learning situation. Remarkably, students were able to maintain a realistic attitude toward the purpose of the course despite the limited technical knowledge to which they had been exposed. They were able to place technical knowledge in perspective and focused on what Habermas (1971) called communicative action.

> Because of today's health care reform we just can't be skill-oriented. The point of reform is to ensure that disease is prevented instead of curing it right? With the focus on disease prevention we need to be able to talk to patients. There are less and less nurses in the hospital and we need to show everyone that we're still important to health care. In this program you learn what to expect. You learn how to deal with patient's emotions and the family (Ellen).

> You learn that people of different ages think about different things. We learned about Erikson's stages and that you wouldn't talk to adolescents the same way you talk to someone who is middle-aged (Sara).

> You learn what types of questions to ask as it relates to what's wrong (Ellen).

Caring for clients provided students with the opportunity to learn from experiences that they will most likely encounter as practitioners. The importance of this client contact is a strength in nursing education (Infante, 1985).

These students attached meaning to an experiential exercise when they could see its intended purpose. For most of the students, the purpose of providing client care to advance their learning was clear. However, there was some confusion about the intended purposes of the associated course assignments. Of particular difficulty was the completion of the health history assignment form.

> I don't know how it's [the health history form] supposed to be filled out. How can elderly people answer these types of questions - how do you describe yourself when you're healthy? I imagine myself as an old person trying to answer these questions and I wouldn't know. I'd say, "what are you asking?" (Ellen).

The health history form was cumbersome for the students and some questioned the usefulness of some of the questions. Students occasionally made up answers to a few of the questions because they

were too "embarrassed" to ask the clients "silly" questions. Conversely, the student participant who was placed in the geriatric setting did not struggle with the assignment. She explained the difference as such:

> These residents want to talk to you. They're not sick. They just live here and they like to talk.

Students were also unsure about how to write a journal or what content it should include. In a discussion about the journal assignment, one student said the often heard words in education, "I'm not sure what they want". Doing assignments "for" the instructor is how many students have been socialized in the educational system. Few students have been exposed to a less directive emancipatory curriculum that encourages shared responsibility for the "educational journey" (Gaines & Baldwin, 1996). Allen (1990) said that rigid control of the curriculum (and subsequently assignments) is a often a result of the perceived obligation of nurse educators to produce "safe" practitioners.

> The combination of an occupational requirement and responsibilities for life and health create a sometimes morally overwhelming burden for educators. It influences our affective and ethical lives as much as our more purely academic lives. I believe a sense of being accountable for such outcomes (whether or not we actually are) creates an anxiety that transfers to our attitude toward students. We see them as a potential threat: if they make serious mistakes in clinical or after graduation, their failure reflects on us. Consequently, we assume the burden of trying to create a fail-safe educational system. (p. 313)

Obviously nurse educators cannot be held accountable for everything students do but when students have little control over their education and are expected to conform, passivity, rather than responsibility, is encouraged (Allen, 1990). Passive learning perpetuates the notion that students (and subsequently nurses) must be told what to do (Hedin & Donovan, 1989). Is this what we want students to learn? In this study the students completed all of the assignments in the course without any frontstage objections but they did question the intent of the assignments in the backstage area. Students were not passive about their learning but were not comfortable in voicing their concerns in a frontstage setting. Subsequently, assignments were primarily completed to meet the course criteria rather than to meet their learning needs.

Summary

The search for comfort was generally a positive experience for these students. Students derived comfort from the support of other students, instructors, staff, and clients although it became obvious that staff and instructors held the most power in making their learning experiences positive or negative according to the level of support provided. As well, the level of support within learning environments fostered or impeded the ability of the students to get their questions answered. The importance of clinical to their search for comfort was again very evident. The value of experiential learning was reinforced by their enthusiastic comments about the clinical environment. Unfortunately, students were unable to derive an equal amount of meaning from the course assignments and resorted to doing the assignments "for" the instructors rather than for their own learning.

CHAPTER VII

Beyond Empathy

> To teach, after all is to engage in an ongoing effort to move others to learn to learn, to come to know, to think to see.
> (Greene, 1986, p. 490)

From a personal perspective, the experience of doing ethnographic research with these students and being a student again has changed how I will teach in the future. As was the case with many of these students, I did what was expected of me as a student. I did not challenge the professors' ideas. I wrote papers 'for them' about what I thought 'they' wanted. I did not try to change anything because getting through the program was more important than challenging educational ideology. I could truly empathize with these students' experiences. But the research path that I chose for my thesis took me on a transformative learning journey that changed my philosophy of nursing education. Bevis (1993) calls this kind of journey "discovery learning".

> Discovery learning is a collaborative journey - where the learner is an equal partner with others . . . . It requires using one's own efforts and relying on one's own power to make sense, meaning, and understandings, and to comprehend the scope of the issues and assumptions surrounding ideas. (p. 104)

The journey caused me to reflect on why I taught the way I taught, the control I held over students in the past, and how, in the future, I can enable the educational experience to be more empowering for students. I can no longer teach to the objectives as if they were sacrosanct. As a nurse educator, I now believe that my responsibility goes beyond

empathizing with the student experience to acting in a way that will provide students with the opportunity to experience "discovery learning".

Teaching, Learning, and Change

The students in this study were the first BScN students to enter the school of nursing since the previous diploma school ended. There were changes, not only to the type of program offered, but in the philosophy faculty and students were to have toward learning. The broad curriculum foundations of the BScN program place value on intuition, critical thinking, praxis, and learning as a reciprocal process. It is not my intent to critique the effectiveness of the curricular ideals but to acknowledge the great challenge of authentic change within nursing education from a traditional curriculum to a more emancipatory curriculum.

Nursing educators have discussed the difficulty of uniting beliefs with practice in nursing education (Rentschler & Spegman, 1996). The ties of nursing education to a behavioral teaching paradigm are historical and many educators have found that changing to a different teaching paradigm is difficult. Many nurse educators have been taught and have taught under a behaviorist curricular model and do not see any need for change. Such a paradigm shift is difficult for faculty who have been embedded in traditional teaching roles (Rentschler & Spegman, 1996). The behavioral teaching paradigm appears to be safer, more predictable, and easier for both students and teachers in the short-term but it has the potential of limiting critical thinking skills that students can use in the rapidly changing health care system (Diekelmann, 1993). The experiences of the students in this study describe a lessened quality of

learning when the teaching environment is behaviorally structured compared to an environment that supports teacher-student interactions in a meaningful way.

One barrier identified in the literature that stands in the way of a more liberatory curriculum is the difficulty for faculty to change from content-focused courses to process-focused courses (Rentschler & Spegman, 1996). These authors note that it is difficult for faculty to "give up" content, develop process-focused teaching strategies, and put themselves in higher risk teaching situations than content-focused classes demand. This is not to say that there is not to be any content in classes, rather, what is important is that students think about what the content means within the context of the situation (Diekelmann, 1993). The students in this study articulated their dislike for content-laden lectures and their preference for discussion related to the topic areas. Some viewed lecture as boring and unrelated to the experiential nature of nursing practice. Clinical practice, in particular, was process-focused and students drew a great deal of meaning from this type of learning experience. In these situations, students moved from being receivers of information to subjective knowers (Belenky et al., 1987) and teachers moved from giving information to exploring meaning with students (Diekelmann, 1989). "Such a relationship between teachers and students recognizes the growing diversity in our student population, and the tremendous talents that these women and men bring to nursing practice" (Tanner, 1990a, p. 72).

As nurse educators we need to challenge the notion that the goal of nursing education is to "prepare" nursing students for employment

rather than to educate students capable of participating in, and changing for the better, the health care system (Tanner, 1990a). Student participants in the study were already aware that the focus of health care is changing and that the traditional ideas held about what nurses do cannot be maintained and that they will be expected to practice differently in the future. Allen (1990) asserts that a consequence of trying to prepare the student with "the right" content for practice is that the student then believes that s/he must be expert in all aspects of care. He states, " we waste perfectly good trees producing elaborate syllabi so they can jot down all our important information, and we give them 10 cents worth of knowledge on a thousand topics" (p. 314). Conversely, teaching for transformative learning includes problem-posing, subjective testing, journaling, student self-evaluations, independently designed projects, and paradigm cases among the many teaching options suggested (Hedin & Donovan, 1989; Nehls, 1995; Rentschler & Spegman 1996).

Rentschler and Spegman (1996) found faculty feared that a humanistic-educative curriculum would not produce outcome competencies in students that would reflect success in the national nursing examinations or meet accreditation standards. However, even national examinations are being challenged for their ability to reflect professional understandings and decision-making abilities, and the criteria and processes used to accredit schools of nursing are also being challenged for their lack of cultural context, exclusion of marginalized persons, using a manufacturing model to produce nurses, and encouraging conformity and obedience to certain practices (Allan, 1990; Rentschler & Spegman, 1996). Some schools of nursing choose not to

recognize accreditation as a necessary process. The issue that perhaps should be challenged is whether students benefit from the accreditation process or not. Is there an acknowledgement of the cultural diversity in cohorts of students between schools of nursing? Granted, there are barriers to challenging any accreditation process or national examinations and the purpose of this thesis was not to explore those issues in depth but this study does challenge nurse educators to recognize their assumptions entering a teaching environment and should acknowledgement of those assumptions not occur at a greater administrative level?

A second barrier that lies in the way of a more liberating education is related to evaluative practices. Just as there is a call to revise curricular philosophy, content, and evaluative processes, there is a demand in society for schools of nursing to 'produce' nurses who function within "accepted frameworks of knowledge" (Greene, 1986) and meet institutional/community expectations of practice. Nurse educators try to meet external demands by supervising and evaluating every aspect of student behavior to protect themselves emotionally and practically (Allen, 1990). It was the inflexible ties to content and evaluation that limited, but did not exclude, learning for the students in this study. There was, for these students, an uncomfortable fit between the discourse of establishing a caring, human connection with clients (simulated or otherwise) and the discourse of the evaluative criteria. The subjective contextual nature of both classroom activities and clinical practice was constructed to fit a grade that may or may not have reflected the students' perceptions of their knowledge about, or comfort

with, client care. It was through clinical practice that a transformative learning experience occurred for most students. It was caring for clients that affected and changed the values and beliefs that students held about nursing and nursing care. As Nelms (1990) states:

> In all our years of trying to fit nursing curricula into the behavioral rationale, the one thing that never quite fit was clinical. Yes, we planned for it and wrote objectives for it and even tried to measure and grade it, but we always accepted that on some level it would be serendipitous. (p. 290)

Gaines and Baldwin (1996) recommend that a critical first step to altering traditional ideas about evaluation is to recognize that course objectives can be met in a number of different ways. Symonds (1990) says that if academic institutions control all the decision-making processes then the teaching-learning process only comes to reflect traditional institutional values rather than mutually supportive values in the student-teacher relationship. In the behavioral teaching paradigm successful teaching and learning is easily tested and measured by grades and evaluations. In a more liberatory curriculum, teaching and learning is more uncomfortable. Outcomes are less tangible and the assumptions that both teachers and learners enter with into the learning environment are challenged (Rentschler & Spegman, 1996). The behaviorist teaching paradigm depicts the teacher as knower but in a liberatory curriculum the power differential is diminished and the teacher becomes a learner with the students (Diekelmann, 1989; Gaines & Baldwin, 1996). Greene (1986) acknowledges that the problem for the teacher then becomes "inventing modes of access to the empowering skills or techniques

existing in the culture" (p. 488). Chally (1992) writes about the possibilities of empowerment through teaching. She explores a model of teaching that uses the tools of empowerment such as positive self-concept, creativity, resources, information, and support as the means needed to "actualize a shared vision" in nursing education (p. 119).

There was not an atmosphere of 'we' against 'they' during my observations in this study but neither was there the sense that students felt empowered by the educational system. There were feelings of resignation and powerlessness about the structure and evaluation of the learning experiences. These students had little success in their efforts to change the educative process. Students need to believe that they have some control over their education, the freedom to speak when situations are oppressive, and to believe that they will be heard. By making visible to students the power relationships that exist within an evaluative process, the power balance can be shifted to become more egalitarian if there is a committment by faculty to authentic change. Chally (1992) notes that "the process of empowerment is propelled by the mutual exchange of energies between students and teachers. The exchange of these energies is continued, intense, and frequent" (p. 118).

Philosophical barriers to authentic change in the educative process in nursing also exist. If an emancipatory curriculum is to exist there needs to be a philosophical shift in the responsibility of learning from the faculty member to the student. Faculty responsibility is to facilitate learning recognizing that students must be trusted to understand, apply, and contextualize information within student-directed learning activities (Rentschler & Spegman,1996). As identified in this study, when teaching

priorities are identified as those activities that are teacher-generated and graded, most students will choose not to independently initiate learning activities or take ownership of material that "isn't on the test". In learning environments where there is shared power there is implied responsibility (Hedin & Donovan, 1989). A "freeing" education requires confidence in the students and in one's own teaching abilities and there are risks taken by both students and teachers (Hedin & Donovan). If nursing educators have a philosophical belief in the need for structure and the requirements for rationality then these beliefs will be reflected in a "cognitivist" emphasis in the learning environment (Greene, 1986) which is in contrast to an emancipatory curriculum.

Academic freedom in itself implies that educators interpret and implement the curriculum using their own knowledge and teaching experience. However, if there is to be any understanding of the principles of an emancipatory education, nurse educators must look at their educational assumptions entering the student-teacher relationship. By deconstructing their philosophy and assumptions about the student-teacher relationship the "hidden curriculum" or "the curriculum of subtle socialization" is uncovered (Bevis, 1989, p.36). Subtle socialization for both students and educators occurs within and outside of nursing education environments and thus uncovering one's assumptions is critical to understanding how one enters a teaching situation. Bevis (1989) says that it is through faculty development rather than curricular rearrangement that faculty are helped to alter their perception of their role. There is a need for more faculty connections, networking, and support systems within educational environments for emancipatory

action among faculty rather than the content-focused workshops that usually occur. Bevis states that "if faculty development is successful, the curriculum will change as a natural consequence of faculty dialogue" (p. 49).

Another barrier to learning that the students became aware of was the power others had in making the environment uncomfortable for learning. The students clearly articulated when they felt comfortable uncomfortable in learning environments and what made them feel more comfortable. Nurse educators can tranfer this knowledge to their own practice if suitable and subsequently foster those "comfortable" environments by facilitating peer support networks and other connections among students. This issue can also be discussed in terms of caring. Although the students did not express themselves in terms of feeling cared for (or not cared for) within the educational environment, they did identify caring and non-caring practices within the course and how those behaviors influenced their perceptions of the role of the nurse.

Tanner (1990a) advocates for a curriculum that holds caring as a core value. She states, "what it is to nurse cannot be separated from what it is to care for, and about, others" (p. 71). Owen-Mills (1995) argues, though, that "for caring to be taught and experienced in such a way that empowerment for the student occurs, a nurturing and caring learning environment is necessary" (p. 1192). Tanner (1990a) also states that if caring is learned by experiencing caring practices then this is only possible when the school supports enactment of caring practices among faculty. Thus, the barrier nurse educators face in advocating for caring as a core value becomes political in nature.

In the larger social context, the term caring itself is difficult to articulate and define both by nurses and by the public. Indeed, caring is not a term that nursing exclusively 'owns' in the health care field as most health professions perceive themselves to be caring. For caring to become valued in nursing, caring must be seen as central to nursing worklife issues. A nurse who is encouraged to be caring and is not cared for in the nursing environment can hardly be expected to incorporate emancipatory ideology in her/his practice. Still, the perception that a caring philosophy is apolitical in nature could be seen to be part of the difficulty in nursing education.

Lastly, authentic change in nursing education practice stems from the level of commitment to "a different kind of curriculum development" (Bevis, 1989, p. 50). Educators can either ignore or embrace the difficult social issues that exist in society and the subsequent role nursing plays in affecting them. However, issues such as power, violence, abuse, oppression, and militarism cannot be disregarded within a transformative educational environment (Evans, 1994). Feminist pedagogy, as a route to transformative learning, recognizes a commitment to social activism. Feminist teaching reflects the multicultural and diverse natures of clients in the health care system and critiques this same system for neglecting to consider the needs of those marginalized groups at risk in our society (Bent, 1993). Feminist teaching espouses diversity in teaching methods, acknowledges the knowledge students possess, and promotes critical inquiry, questioning, and evaluation of classroom information (McAllister, 1995). Even at a beginning level the students in this study valued the knowledge that they

and other students brought into the learning environment. They were able to derive meaning from classes where there was opportunity to relate personal experiences and hear about the experiences of others. Chinn (1990) identifies that the "skillful crafts of listening and speaking we had learned as both women and nurses" creates new meanings and new realities for participants in a sharing environment (p. 320). To foster and encourage students to understand and embrace values that differ from larger hegemonic values is perhaps one way of introducing change into the health care system.

As nursing education changes so will our ideas about it change. What I hope to communicate is the need to challenge our beliefs about teaching and learning and to be open to the possibilities of alternative teaching paradigms.

Conclusions

Learning cannot be viewed acontextually. The path nursing education is on today is embedded in historical pathways. The learning experiences of this group of women is intimately related to the power/knowledge/class/race/gender issues of the past. For change to occur in nursing education we need to make visible what has been rendered invisible in educational history and within ourselves as educators. The need for change in nursing education also needs to be placed within the present context of the changing health care system. In Canada today, nurses are losing their jobs or finding only part-time or casual work, and they face an uncertain future. The education that they received, in all likelihood, did not educate them for the diverse roles nurses will have to assume or create in the health care system. Political

and social awareness of job-related issues has to become crucial if the profession itself is to be maintained. However, as noted, there are many barriers to implementing a nursing education curriculum that reflects its ideals and that meets the needs of the future.

American nurse educators, in 1987, called for a curriculum revolution as a means to enable individuals to challenge "the patriarchy's values of dominance and control" in the health care system (Moccia, 1990, p. 308). The curriculum revolution was "an invitation to nurse educators to consider both the issues in the health care system and the dilemmas we encounter in our educational programs" (Tanner, 1990b, p. 296). Such a unified position is not as obvious in Canada, although some schools of nursing have constructed their curricula to reflect a caring or feminist ideological standpoint. Advocates for curricular revisioning argue that the traditional behavioral curriculum does not prepare nursing students to be critical thinkers and change is necessary at a curricular level (Allen, 1990; Bevis & Murray, 1990; Hedin & Donovan, 1989; Moccia, 1990; Tanner, 1990b).

Curricular revolution alone cannot change the future of nursing education, there needs to be a commitment among nursing educators to critically examine the societal pressures that shape the construction of nursing education and health care in general. If there is to be a goal of a primary health care system, based on the principles of citizen participation and community development, the students who graduate from health care programs will have needed to be exposed to the notions of egalitarian relationships, non-hierarchical communication, and facilitating connections between people that ground the principles of

primary health care. Developing from this examination there is a personal responsibility for educators respond to (and to teach students to respond to) the social pressures of inequality, power, and oppression in a political forum.

Through the use of feminist participatory research and critical pedagogy, educational issues and nursing worklife issues can be explored in a connected, meaningful way that directly relates to the crises in the practice environment. Futher research in student learning is necessary if we hope to educate students who are prepared to effect change in the health care system. I believe that students need to graduate believing in themselves and their abilities. Thus, further research in needed in the area student "comfort". What can we do to make learning environments safe and comfortable for learning? that promote and encourage creativity and freedom of expression? Examination of these issues through research methodologies that value student experiences is essential. Teaching is not about filling an empty vessel, it is about lighting a fire.

Appendix A

Demographic Information

Age :

Gender:

Marital Status :

Number of Children :

Educational Background :

Previous Work Experience :

Appendix B

Student Participant Interview Probes

Ethnographic research is dynamic and the questions used in the process evolve from the cultural situation. Areas of interest that may be anticipated at this stage may be explored by using the following statements or questions.

1. I am interested in hearing about your initial clinical experiences.
2. I would like to know how you approached this new experience.
3. What have you learned from this experience?
4. How did you learn from this experience?
5. Do you talk to other students about your clinical experiences?
6. Is talking to other students helpful to your learning?
7. Describe an experience where you learned something about being a nurse.
8. Describe your impressions about the atmosphere on the clinical unit.
9. Was the atmosphere conducive to learning?
10. How did you go about fitting in on the unit?
11. What sources of knowledge do you use to help you deal with new clinical experiences
12. What internal factors (values, beliefs) were influencing you during this experience?

Appendix C

Participant Consent

Title of Study: An ethnographic exploration of novice nursing students' clinical experiences: Backstage realities.

Investigator: Elizabeth Richard
Box 27058
Halifax, NS, B3H 4M8
Phone: 423-9105 E-mail: emrichar@is.dal.ca

This is to certify that I, _____ understand the purpose of the above study and have agreed to be a participant. I may refuse to answer any questions and I can withdraw from the study at any time.

I understand that I will be part of an ethnographic research study. I give permission for the formal interviews to be taped with the understanding that I can ask for the researcher to stop taping at any time and that once the interviews are transcribed the tape will be erased or given to me. I also give permission for my actions to be observed and recorded with the understanding that my identity will remain anonymous.

Additional sources of data such as relevant clinical notes and assignments may be requested as part of the observation component but I understand that I can refuse to have the researcher view these documents.

Upon completion of the study I understand that the findings will be placed in library holdings and be retained by the researcher.

I am satisfied that confidentially will be maintained at all times.

_____ _____

Signature of Participant Date

_____ _____

Signature of Investigator Date

Appendix D

Letter of Proposed Research

Elizabeth Richard
Box 27058
Halifax, NS
B3H 4M8
(902)423-9105

March __, 1996
Dear _____;

This letter is in response to your request for an explanation of my proposed nursing research in association with the Master of Nursing Program at Dalhousie University.

With the consent of 10-12 first year baccalaureate nursing students, I am proposing to undertake a three week ethnography of novice nursing students in the ------ Site of the ------ University Bachelor of Science in Nursing Program. I will be observing and interviewing students in their milieu external to formal teaching situations. There will be no evaluative recording of student, faculty, or patient behavior. The purpose of this ethnographic research is to explore the lived experiences of baccalaureate nursing students in an initial clinical experience.

Ethical protocols regarding informed consent and anonymity of the participants will be implemented before the research begins. Approval from the Ethics Committee of Graduate Studies at Dalhousie University will also be obtained prior to conducting the study. I will be introducing myself to faculty, students and the nurse managers on the units the students will be having their experiences to explain the purpose of the study and my role as a researcher.

I would be more than willing to provide any additional information you may need about my proposed research.

Sincerely,

Elizabeth Richard

Appendix E

Letter of Introduction

Hello. My name is Elizabeth Richard and I am a graduate nursing student enrolled in the Master of nursing Program at Dalhousie University. I am interested in observing how nursing students prepare for and learn in an initial clinical experience and having you share what these experiences are like for you. I have always been interested in exploring how students learn about nursing.

This three week ethnographic research will not include any form of evaluation and no observations of direct student-teacher interactions will be make. This is an opportunity for the participants to share their experiences and knowledge.

If you are interested in participating in this research, you can contact me at 742-3993 or I will be at the School of Nursing on April 29th, 1996. I can provide you with more detailed information when we first meet.

I would like to thank you in advance for your consideration of this request.

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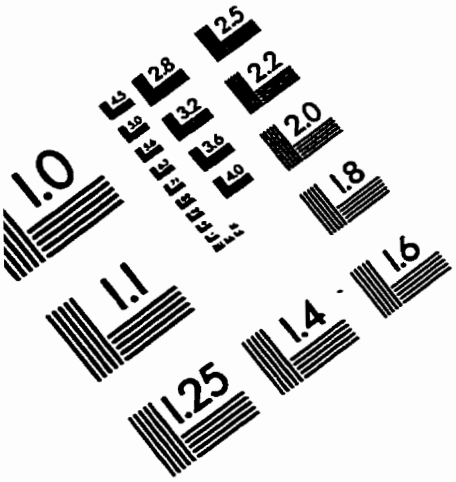

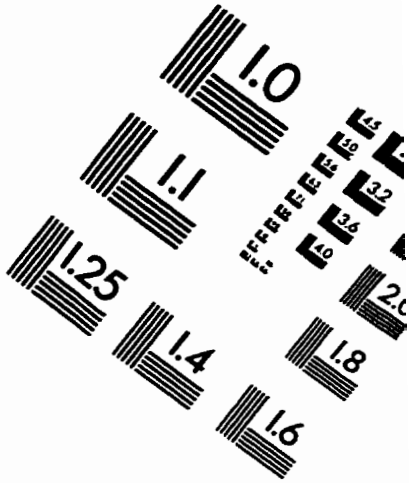

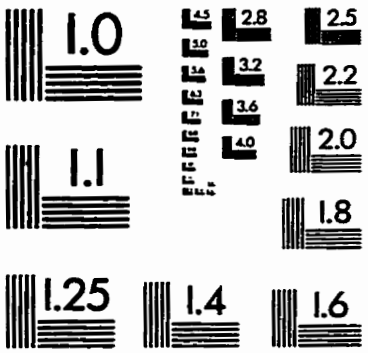

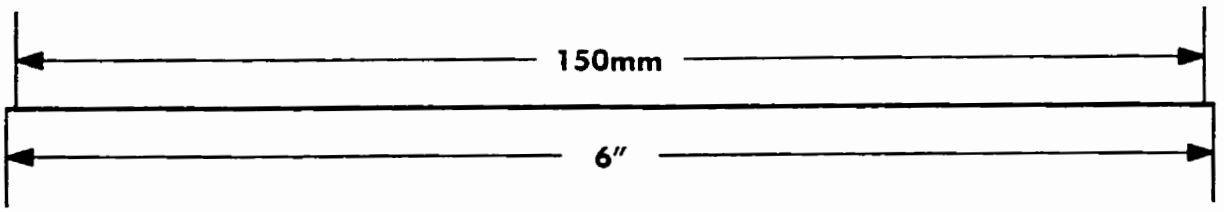

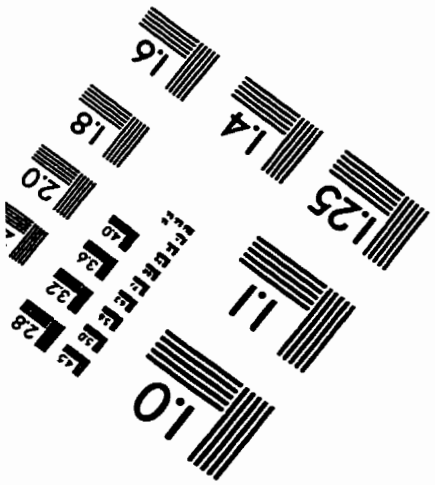

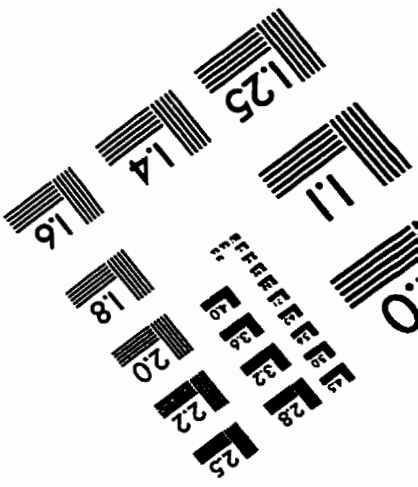

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