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Shaping nursing knowledge

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SHAPING NURSING KNOWLEDGE: AN INTERPRETATIVE ANALYSIS OF CURRICULUM DOCUMENTS FROM NSW AUSTRALIA

by

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Dedication

To my parents, Jean and Cecil Love, who not only gave me life but taught me to ask questions.

To the memory of my husband, Allan Dunlop, whose sense of humour so often turned the world of experience upside-down and whose life was proof that men, too, can be deeply involved in caring.

To my many colleagues in nursing with whom I have worked, talked and argued over many years within a background appreciation of and love for this vital caring profession.

PREFACE

> Upon the earth and in it, historical man grounds his dwelling in the world. In setting up a world, the work sets forth the earth.... Earth juts through the world and world grounds on the earth only so far as truth happens as the primal strife between lighting and concealing.... Setting up a world and setting forth the earth, the work is the instigation of the strife in which the unconcealedness of beings as a whole, or truth, is won.
> (Martin Heidegger - The Origin of the Work of Art, in D. Farrell (Ed.), 1977, p. 171)

It is time to tell a story--not just any story, but a story about nursing and its quest for a knowledge base. The test of any story is its truth--its ability to reveal what had been concealed, its ability to bring into the light aspects of being-in-the-world that were previously concealed or taken-for-granted and thus not really "seen." The test of the truth of any story worth telling is its ability to reveal to us certain events in the world in a new light, although, as Heidegger argues, that new light also contains concealment.

Not just any story will do. To be a true story (the kind worth telling), the story must pick up the knowledge and thinking of the time and provide an interpretation which is compelling and convincing to beings-in-the-world of its time. While we say of great works of art that "they have stood the test of time," what we seem to mean is that they are still capable of interpretation within the present time. If one is prepared to immerse oneself in the socio-cultural history of the time that they were created, a quite different interpretation

emerges into view, and things puzzling and strange about the apparently eternal work of art fall into place.

So the story must be a story for its time--which does not mean that it is limited to the present moment of time (an impossibility anyway). To be true, it must make sense by drawing on our knowledge and understanding of the past, and interpreting that past for us in the present.

The telling of a particular story does not exclude the telling of other stories on the same terrain. But each story will both reveal and conceal, as the angle of the light that is shed changes (Heidegger, in Farrell (Ed.), 1977). What I intend to present is one way of looking at the problems nursing has had in establishing its knowledge base--the one which seems most compelling and explanatory to me. There is always the possibility that I am telling the story only to myself, although this is doubtful. For I dwell in the world of intersubjective and communal meanings and understandings which is nursing and any story I tell must almost of necessity link into those meanings and understandings.

The story has been emerging in my consciousness now over a period of at least ten years, although probably longer. As it has emerged, I have told it to my students, sharing with them my puzzlement about certain aspects of it that were still concealed from view. They have shared in its development, and they have given me confidence that the story has meaning, that it helps to make sense of what is going on, that it helps to explain the problems that continue to confront nursing as it seeks to establish a more openly acknowledged place in

the world.

There is now a new urgency to the task of telling the story, as I confront at first-hand in the Australian setting the same sorts of problems which America confronted at an earlier period of time. Problems which before I could simply allude to, bring to the awareness of experienced nurses, discuss with them, now are confronting us in all their immediacy, as nursing moves out of the hospital-based schools of nursing and into the higher education system. What is nursing? What do nurses need to know? How can we best provide neophytes with a basis for nursing practice separated from the traditional learning-on-the-job? How can we express nursing knowledge in a sufficiently theoretical way that it satisfies the criteria of academia? More importantly, how can we develop frameworks which allow for the growth of knowledge? Telling a story alone will not solve these problems but, if true, will help to clarify the problems and suggest ways in which we might start looking for answers. For those who believe we already have the answers, this will be "just a story," but, even so, I trust, an interesting one.

As Taylor (1984) asserts, in the context of a discussion of political theory,

> [O]ur society is a very theory-prone one. A great deal of our political life is related to theories. The political struggle is often seen as between rival theories, the programmes of government are justified by theories, and so on. There never has been an age so theory-drenched as ours. (Taylor, 1984, p. 106).

The story I seek to tell is about theories. I hope to bring together in the telling of the story of nursing theory, theories from outside

of nursing which may help to elucidate the position of nursing. On the assumption that nursing deals with human beings in their beingness, that its concern is a holistic one, it seems reasonable to draw on post-Heideggerian understandings of being-in-the-world that run counter to or complement atomistic accounts. On the further assumption that nursing is predominantly the work of women, the concealed underbelly of modern medicine which is now coming into view as women assert the importance of their work in the world, it seems important to also draw on the body of theory which is now developing out of the feminist movement which critically examines the exclusion of the feminine from Western intellectual discourse.

I situate myself, therefore, at an intersection between the developing hermeneutical tradition and developing feminist ontology--a somewhat uncomfortable position because these two bodies of thought, equally critical of Cartesian dualism, seem not to have yet fully realized the contribution each can make to the other. But I am convinced that, if indeed a post-Cartesian consciousness and understanding of the world is emerging, then at least these two strands of thinking need to have a share in its making. Since the feminist position, on past history, is the one more likely to be submerged, to believe otherwise is to sentence women once again to a marginal position in the intellectual tradition, accepting their contribution only to the extent that they learn to "think like a man." The insights and understandings developed in the female culture would, again, be lost to view.

In such a situation, nursing could only develop intellectually by

cutting its ties with the female world--something which (I will argue) it has so far been loath to do. Perhaps cutting is too sharp a word--it is more likely that nursing, as it seeks to develop intellectually, will gradually attenuate its ties to the female world unless the intellectual world into which it is developing changes in a way that allows for the full intellectual expression of "the feminine".

In speaking of "the feminine," I must enter the usual caveat. The world presents us with feminine and masculine stereotypes which strongly influence but do not completely determine the way of being-in-the-world of women and men. It can be reasonably argued that the presentation of these different models of what it is to be a human being set up differing sets of relationships--indeed, different worlds. The argument goes further than this, for the predominant public view has been the masculine one, and the feminine has been either ignored or explained in its categories. But the worlds of individual women and men may differ, by greater or lesser extents, from those the stereotypes alone would induce. The development of human beings is far more complex than their shaping to pre-determined patterns, which, in any case, are changing ones.

Nevertheless, it is still useful to use the terms "feminine" and "masculine" to refer to particular relations with the world that develop through differing socialization, orientation, and involvement with it (probably also through differing physiology--not just reproductive--but body shape and structure).

In "The Origin of the Work of Art," Heidegger uses as an

illustration Van Gogh's painting of a woman's peasant shoes.

> A pair of peasant shoes and nothing more. And yet ... From the dark opening of the worn insides of the shoes the toilsome tread of the worker stares forth. In the stiffly rugged heaviness of the shoes there is the accumulated tenacity of her slow trudge through the far-spreading and ever-uniform furrows of the field, swept by a raw wind. On this leather lies the dampness and richness of the soil.... This equipment belongs to the earth, and it is protected in the world of the peasant woman. From out of this protected belonging the equipment itself rises to its resting-within-itself. (Farrell (Ed.), 1977, p. 163)

There arose in my mind the vision of another pair of shoes, equally worn, although shaped in a different way. In the Nurses Home at Alice Springs Hospital, in the hot red centre of Australia, a nurse had placed her shoes on the fanlight of her door to air before her next day's work. A sight once commonplace impacted on me because I had been removed from such sights for some time. Low-healed, "practical," worn and scuffed, these shoes, too, speak of a world--as with the Van Gogh's painting a very taken-for-granted world. As with the peasant woman

> If only this simple wearing were so simple. When she takes off her shoes late in the evening in deep but healthy fatigue, and reaches out for them again in the still dim dawn, or passes them by on the day of rest, she knows all this without noticing or reflecting. The equipmental being of the equipment consists indeed in its usefulness. But this usefulness itself rests in the abundance of an essential Being of the equipment. We call it reliability. By virtue of this reliability the peasant woman is made privy to the silent call of the earth; by virtue of the reliablity of the equipment she is sure of her world. World and earth exist for her, and for those who are with her in her mode of being, only thus--in the equipment. We say "only" and therewith fall into error; for the reliability of the equipment first

> gives to the simple world its security and assures to the earth the freedom of its steady thrust. (Heidegger, in Farrell (Ed.), 1977, pp. 163-164)

The nurse's shoes also speak of the situatedness of nursing work, of its obdurate physicality, the involvement of the nurse's lived body in her work.

The shoes provide a symbolic counter-point to "dematerializing" trends in discussions of nursing, trends which seek to translate the embarrassment of lived-body experience into the language of the mechanical body and that of a psycho-social entity with which it is thought to interact. Thus the lived-body experience of both nurse and patient is covered over. In simple language, the world of aching feet, bedpans and vomit-bowls drops from view, although not from lived experience.

It will be objected that not all nurses today wear "nurses' shoes," that nurses these days are concerned with "health" rather than "illness." While it is true that nurses are developing new roles (or expanding existing ones), some of which are outside illness settings, pressing the issue too far runs up against the obdurateness--the givenness--of the world (which is how I understand Heidegger's use of the term "earth"). In simple words, people still get sick, despite our best preventive efforts (which are, as yet, far from optimal), and the sick need care. While one can imagine a world in which care would not be given, it is demonstrably not our world, and even the imagination of such a world affronts our moral sensibilities as human beings.

Any adequate account of nursing must, therefore, in Heidegger's

terms "set forth the earth" as well as setting up a world, as he claims the work of art does. The two are inextricably intertwined.

To put it another way, not just any theory will do, as Taylor argues in the context of the social sciences.

> The other simple inadequate model of the relationship is to jump from the above (demonstrable inadequacy of the correspondence account) to the conclusion that thinking makes it so. But this clearly will not do either, since not just any new definition can be forced on us, nor can we force it on ourselves; and some which we do gladly take up can be judged inauthentic, or in bad faith, or just wrong-headed by others. These judgments may be wrong, but they are not in principle illicit....
>
> Thus, neither the simple correspondence view is correct, nor the view that thinking makes it so. But both have prima facie warrant. There is such a thing as self-lucidity, which points us to a correspondence view; but the achievement of such lucidity means moral change, that is, it changes the object known. (Taylor, 1984, p. 126)

Nursing has been struggling toward self-lucidity and, in the process, transforming itself. But, I will argue, the gaps between nursing practice and nursing theory suggest the need for the development of a greater lucidity and not just, as it is often put, "testing theory in practice," a view which tends to impose the theory on the practice, rather than seeing the knowledge embedded in the practices themselves.

It is in this context that the work of Patricia Benner, based on Heideggerian hermeneutics, can be seen as providing an alternative path to self-lucidity in nursing by uncovering the knowledge embedded in clinical practice (Benner, 1984). My own thinking about nursing knowledge has been very strongly influenced by her approach, although

the full implications of her approach for nursing knowledge development (and for its teaching) await exploration. But the potential is within the approach to transform the way we think about nursing and the way we teach (or, rather, learn) it.

The material presented here can be most appropriately regarded as a journey toward understanding, toward lucidity, which is still far from complete and which, in principle, can never be complete because that would be to close the path to further development of understanding.

Many people have contributed to this journey toward understanding, not all of whom have published material which could be cited here. As a teacher, I have experienced the great joy of learning from my students who are also my colleagues in nursing, particularly in the conversations that occur outside the formal classroom setting and in their written assignment work.

Colleagues past and present of the Center for Nursing Studies at Armidale College of Advanced Education (now the University of New England) have also listened patiently, argued with me and have been a continuing stimulus to my thinking. In the context of thinking about nursing knowledge, I would like to acknowledge Jocalyn Lawler who developed teaching material in the area with me, and Jan Brown who has more recently made a similar contribution. I also owe a debt to my nursing colleagues in other Australian educational institutions with whom I have been involved in the development of programs for registered nurses as well as basic professional preparation.

During the period spent as a student at the University of

California-San Francisco, my thinking was greatly challenged and enriched by my contacts with faculty there. Patricia Benner has been an invaluable source of challenge and encouragement as chair of my dissertation committee, but important contributions to my thinking have also been made by Virginia Oleson, Afaf Meleis, Susan Gortner, Anne Davis, Sheryl Ruzek and many others. Also very significant has been the exchange of ideas with my fellow students in the doctoral program.

The Kellogg Foundation provided me with the fellowship which made it possible for me to complete my initial two years of study in the USA, and I am very grateful for that assistance. I am also grateful to the Armidale College of Advanced Education (now University of New England) for allowing me six months paid leave to complete this dissertation.

Chapter IV of this dissertation has been published as an article in the Journal of Advanced Nursing, but is included here to provide the necessary continuity, with the appropriate acknowledgment in the form of a footnote. This work was completed as part of my enrollment at the University of California-San Francisco.

My final thanks goes to Tess Joseph for her enthusiastic attention to the processing of this dissertation (including the "correction" of my habitual Australian spelling to the US norm).

Margaret Dunlop

Shaping Nursing Knowledge: An Interpretative Analysis of Curriculum Documents from New South Wales, Australia

Abstract

Informed by feminist and Heideggerian insights, a wide range of nursing and non-nursing literature is drawn upon to elucidate the emergence of modern nursing and its quest for its own knowledge base. Attempts to structure nursing as a science are critically evaluated. Caring, in its modern sense, is seen as an emergent construct, directed at redressing the deficiencies of "people work" in the public domain. The reasons why this construct has resisted scientization are explored.

Connections between curriculum development and nursing's quest for its own knowledge base are explored through the US literature. This exploration provides a basis for an interpretative analysis of the guidelines and curriculum documents produced in NSW Australia as a result of the total system transfer of basic nursing education from hospital-based apprenticeship style schools of nursing into higher education institutions at tertiary diploma level (three years full-time study). This move commenced in 1985 and was completed by mid 1987. The difficulties that were experienced in re-shaping the nursing knowledge base in ways appropriate to university-type teaching are used to throw light on the continuing problems of formalizing nursing knowledge. The researcher was a situated participant in this process.

The author argues that attempts to encapsulate nursing knowledge have failed and were probably based on an over-simplified understanding of the complexities of other disciplines. Further difficulties occurred because of nursing's origin in the traditional female world of care and nurturance. Feminist scholarship has argued the inadequacy of the dominant ontology to provide visibility and expression for traditional female knowledge, understanding and skills. The author argues for an opening up of nursing discourse to allow it to develop in a richer way guided by the cares and concerns of its practice.

This work can best be considered as a contribution to the ongoing self-understanding of nursing.

Patricia Benner

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CHAPTER I

KNOWLEDGE AND PROFESSIONAL NURSING EDUCATION

Things fall apart; the centre cannot hold;
Mere anarchy is loosed upon the world,
The blood-dimmed tide is loosed, and everywhere
The ceremony of innocence is drowned;
The best lack all conviction, while the worst
are full of passionate intensity
(W.B. Yeats, "The Second Coming")

Anger and tenderness--my selves
Yet now I can believe they breathe in me
As angels, not polarities.
(A. Rich, "Integrity")

The position I take on knowledge is that of something which permeates us, which, in so doing, shapes the world for us and thus shapes our actions in the world. It is a web which we both weave and are woven by. What we know, sense, and feel (and these permit no clear demarcation) shape ourselves and our actions and, in turn, our actions shape the world for us and others.

I thus endeavour to situate myself where Heideggerian phenomenology and feminist ontology intersect. With Heidegger, I agree that the world is generally experienced as ready-at-hand as the embodied intelligences that are ourselves, for the most part, act smoothly and unselfconsciously in a meaningful world created by our cares, concerns, and commitments. It is only when this world becomes problematical that we resort to the more clumsy present-at-hand stance by which self-consciously, we objectively examine the area that is

causing a problem. But such "objectivity" can focus only on a particular flaw in the web, and not on the whole web itself. In our "objectivity" we remain situated beings and our situation determines the focus of our "objective" gaze. In other words, our cares, concerns, and commitments determine the flaws that we will find troubling and "objectify" to endeavour to do something about.

The metaphor of the web comes from feminist ontology, an ontology that has arisen as feminists have explored their dissatisfactions and discomforts in simply taking on the male way of being-in-the-world as it currently presents itself. The web speaks of the greater sense of interconnectedness with others which many women are reluctant to abandon to achieve a "separative self" (Keller, 1986)--a self self-enclosed and armoured against the in-flowing (in-fluence) of others and the world. Whitbeck (1984) uses the analogy of the web to replace the self-other dichotomy with the interconnectedness of self and others, the self being formed and continually reshaped in the matrix (with its maternal connections) of our relationships with others and with the world of things.

Against this background, Cartesian dualism is seen as the peculiarly modern form of an old male quest to find absolute truth or incontrovertible knowledge by endeavouring to disentangle themselves from the web--to stand outside it completely and to subject the whole of it to the objective gaze of the separative intellect. Many feminists would argue that such a quest has only been made possible at all by the presence in the world of subject castes/classes (women and slaves in ancient Athens, women today) who pick up the pieces of the

world shattered by the separative ego. Thus the title of Keller's book (From a Broken Web, Separation, Sexism and the Self) picks up Adrienne Rich's metaphor of the spider, whose genius is

> to spin and weave in the same action
> from her own body, anywhere--
> even from a broken web. ("Integrity")

Keller (1986) demonstrates how even modern existential thinkers like Kirkegaard, Sartre, and Neibuhr retain an essentialism with regard to the "nature" of women which contrasts sharply with this rejection of essentialism with regard to men. Even de Beauvoir (1952), despite her shrewd analysis of the position of women, glorifies the separative male self, seeing women's quest for an authentic self taking a similar form.

The developing feminist ontology could be seen as a very self-conscious attempt by women to resist the sort of co-optation into the male ordering of the world that de Beauvoir was apparently unable to avoid. While in many ways feminist ontology resembles post-Heideggerian ontology, it differs in its focus on exploration of women's mode of being-in-the-world. It is, after all, no news that we are embedded in worlds of relationships, that our lives are directed by our care and concern for others, that we are very much embodied selves. These are the sort of things on which men have long depended, but for which also they have trivialized us. If men have belatedly discovered that this is also true of themselves, as a woman one can only say, "Welcome to our world."

Yet, post-Heideggerian ontology and feminist ontology are coming from opposite poles of the long established female-male dichotomy. If

the men have been discovering the mis-take of the world that arises from an excess of separation, women have been exploring the dangers and pitfalls of the "too soluble self," as Keller (1986) puts it, which might be understood as a lack of a positive sense of being-in-the-world, not unrelated to the trivialization of our cares and concerns, and, indeed, our work, by the dominant male ordering of the world. (It is, after all, interesting, that Heidegger uses a hammer and nail as a central analogy and that he sees language as primordial rather than the sensing/feeling which is our first experience of the world, as any mother is aware).

To get out of the trap of the "too soluble self" requires a quite different approach to that of the male moving away from the "too separate self." Keller explores the way in which the male definition of sin as arising from the too-vaunting ego has pushed women into a more compounded position of self-lessness, as they have applied sins defined by male experience to themselves. Too close a following of post-Heideggerian ontology would seem to pose a similar danger--that of increasing the solubility of the female self.

Thus, in reaching for a world beyond female-male dualism, men and women need to take separate paths toward a centre which, then, despite Yeats, may hold.

The vision for women that Keller draws from Rich's poem "Integrity" is of

> A person ... who knows her own endurance as web-like, woven of the complex integrity of her unfurling selves, each at once receptively, patiently feeling the world as it is, and creatively, urgently making the world as it will be. (Keller, 1986, p. 224)

The positive experiencing and using by woman of her "many-selved self," formed by the in-fluence of her relationships with other selves and the world of things is thus seen as a path to self-affirmation (or integrity) that differs from the rigid ego-boundaries of the separative self, yet provides meaningful knowledge of self, others, and world.

This, of course, will not satisfy those who still seek the philosophers' stone of incontrovertible knowledge, which has, however, proved remarkably elusive. In the modern age, great faith has been placed in science to provide such knowledge--to explicate the world, to lay it open to our gaze and to our control. Science can be regarded as a very rigorous attempt by the separative ego to systematize our knowing, sensing, and feeling. At its extreme--the vision of scientizing all and thus controlling all--it is the hubritic dream of man become God, omniscient and omnipotent.

This is not to deny science its rightful place in the web of human knowledge of which it is now an integral part. But scientized knowledge only occurs here and there in the web, and, meanwhile, the web continues to be spun as human beings continue to shape and to be shaped by their world. Anyone who decided to act only on the basis of scientific knowledge would immediately become paralyzed, like the "hero" of Browning's poem, "The Grammarian's Funeral," who decided to learn all there was to know before starting to live.

Moreover, science itself is part of the web--or is an activity embedded in a context which shapes its assumptions, its methods and its findings, as we have become increasingly aware. This is most

worrying to those who still look for some type of absolute certainty. The rest of us can feel a certain concern as we might for our own temporality and get on with the business of knowing, as of living.

On this view of knowledge, we as individuals increase and deepen our knowledge through our experience of the world, including our experiences of other beings-in-the-world. The more open we are to having our ideas changed by experience (including scientific findings), the more we are able to learn and understand. We have a word, "wisdom," which is our acknowledgment of this, the getting of which is a lifelong experience. Wisdom has been somewhat devalued by our modern emphasis on scientific knowledge, yet today a reasonable view of wisdom would see it as incorporating science as well as our less formal ways of knowing and learning.

We all utilize knowledge, but professionals are paid to become specialized in some branch of knowledge and its accompanying skills which can be applied to assist others whose knowledge of the area is more general and less detailed. They may be paid from the public purse, on a one-to-one basis or a mix of both. They have an increasing tendency to make the claim that their knowledge is based on "scientific findings," but professionals who restricted themselves to such knowledge would also be paralyzed, unable to act for the benefit of the public, either generally or particularly.

In this view, the claim of nurses to be professionals becomes unproblematic. Nurses are paid to provide a service, based on specialized knowledge, which contributes to the welfare of the public in both general and more individualized ways. That this knowledge

by-and-large is not cast into a scientific format, but is deeply contextual and experiential, as Benner (1984) argues, is interesting but not disqualifying, as it is often seen to be. It is interesting, because nursing can be viewed as the extension into the public domain of women's traditional patterns of developing knowledge, as I will argue in the next chapter.

It may be objected that this approach obliterates the traditional distinction between "profession" and "trade," but I am inclined to agree with Ehrenreich and English (1972) that such a distinction is sexist, racist and classist, preserving a position of elitism for white anglo-saxon middle-class males and those others they can co-opt to their view of the world. As Hughes (1971) argues, sociologically the distinction seems to be one based on how far one can distance oneself from the dirt and the mess by creating subclasses within one's general occupational grouping that can deal with them--with what Yeats calls "the fury and the mire of human veins" ("Byzantium").

Doctoring and nursing can be regarded in this light, the patterning based on the old male-female dichotomy, even though more women are now becoming doctors (forming a subclass within doctoring), and a few more men are becoming nurses (with a distinct tendency to move into the more elite nursing positions). Although, inevitably, there is much commonality in the knowledge-base of the two occupations (they both draw on the body of public knowledge we call medicine), the different orientations to knowing resulting from different relations to the world (explored above) produce distinct differences between a predominantly male structured world of doctoring, and a mixed

structure world of nursing.

The mixed structure arises from the dominance of the male world, with its ability to impose its priorities and concerns onto the female world, at least in part. But, as Benner's research shows, there is also another world at work in nursing which links with the traditional female mode of caring--activity that is carried out by situating oneself imaginatively and sensitively in the world of the cared-for. The phrases that nurses have used to try to encompass this concern--holistic care, meeting all the patient's needs, total patient care, individualized care--have become rather hackneyed and should rather be understood as the metaphors they are. The literal interpretation of them in the guise of "nursing science" proliferates a potentially infinite list of possible nursing concerns, attested by the lengthening of nursing histories and nursing care plans in a futile attempt to encompass "everything." Nursing curricula partake of the same problem.

Recognizing this mixed heritage provides us with a way of looking at problems of nursing knowledge. Within nursing, there are those who are endeavouring to model the knowledge base on the sort of pattern that has proved successful for doctoring, that is, in the development of a set of nursing diagnoses and treatments. This can be seen as equivalent to the liberal feminist quest for equality within a world that remains structured by norms developed through male experience. As with liberal feminism, to succeed this approach to nursing involves abandonment of the values of the traditional female world from which we emerged. Very tightly tied to the nursing diagnosis and treatment

approach is the operation of self upon the world of the other, however softened by "consultation."

The major alternative to this is a view of nursing knowledge as contained within and emergent from the situation. It is contained within because the information and understanding needed is present-at-hand (to use Heidegger's term), and it is emergent from in that it reaches creatively beyond the situation and, in doing so, develops deeper knowledge and understanding. As Benner (1984) argues, this sort of smooth functioning knowledge and understanding arises very much from previous knowledge and experience, so that the emergent knowledge then feeds into future situations. It could thus be seen, in Keller's terms, as the receptive, patient feeling of the world as it and the creative, urgent making of the world as it will be. This is how Benner claims expert nurses practice at their best. It is thus more consonant with the emergent feminist ontology, arising from radical, rather than liberal, feminism. Thus, innovative practice can create and constitute new possibilities, in contrast to the Enlightenment tradition which sees only theory as liberating (Benner & Wrubel, 1989).

But this approach seems to require a radical shift in the way nursing knowledge is learned and thus ties in with the recent US "curriculum revolution" movement, as I will explore in Chapter VII. Experience alone is a long way of learning and we, as human beings, have attempted to hasten the process by formal processes which allow the more knowledgable to transmit more directly what they have learned to the less experienced. Such transmitted experience has less

immediacy than our own experiences, but can considerably speed up the learning process. Such transmission can take place in the face-to-face situation or via media which the modern world has proliferated well beyond the original manuscript or book. (Mediated experience in this sense today makes up a large part of our knowledge, allowing us to learn from people widely separated from us in space and time. One cannot today talk with Karl Marx, but one can read Das Kapital.)

The very proliferation of such accumulated experience often seems overwhelming. It has become fashionable to talk about "the age of information" and we certainly live in a world that runs on information, with its concomitant need for specialists ("knowledge workers") to master to the best of their ability certain areas of it. Yet information is knowledge in a very concrete form--as facts, rather than process. As such, it can be an impediment to the type of learning discussed above because of its tendency to close off our interaction with the world of experience. We imagine that we now "know that" for all time, or, at least, until we forget it. Knowledge in the form of information becomes product rather than process.

To an extent, this is unavoidable in our attempts to manage our very complex worlds, but transmission of knowledge as information alone hardens the arteries and, in attempting to expedite learning, tends to block the development of the learning process, making less likely the development of the flexible approach to knowledge and its application described above. Traditional patterns of schooling, from which schools have been trying to move away, involved teaching of

information and pre-digested skills at its lower (universal schooling) levels, re-socializing an elite at its higher reaches to be the producers of new knowledge. This approach excluded the majority of the population (including most women) from seeing themselves as producers of knowledge--as themselves creators of meaning in the world.

At its best, teaching preserves the openness to experience of both teacher and learner so that coming-to-know becomes an ongoing experience for both. One of the criticisms that can be made of nursing curricula is their relative failure to do this (a criticism from which the preparations of other professionals are by no means exempt). Nursing curricula have tended to follow the traditional pattern of universal schooling. With the old-time nursing curricula, the amount of on-the-job learning tended to counteract this, but it also limited the information base and the breadth of experience (limited largely to the employing hospital).

As nursing moved into colleges and universities in the United States, the formal teaching of an information base was considerably expanded, but clinical experience was increasingly seen as the application of such information (as is clear in the use of the term "clinical laboratory"). "Integration of theory and practice" was seen to involve the use of clinical experience to allow students to apply classroom knowledge. As Diekelmann (1988) argues, there was an assumption that knowledge taught in the classroom could be unproblematically transferred to practice. Clinical practice, transmuted into clinical laboratories, was increasingly formalized

along Tylerian lines, with teacher-specified objectives against which "student performance" could be evaluated. Thus, clinical placement became not so much a means of learning, but an arena in which to demonstrate that one has learned.

But the clinical situation is an open one--full of possibility. To ensure that students learned the "right" things, it became necessary for the classroom teachers to "follow up" their teaching in the clinical setting and this became a prevailing ideology (as it did in Australia), although its implementation was always problematical because of the number of students and sites involved. As what was taught in the classroom deviated more and more from practice, the need became even more imperative. The ideological move to free nursing from its tutelage to medicine--to build its own knowledge base--in which the curriculum became a tool (as I will argue in Chapter VII) widened inevitably the gap between classroom teaching and clinical setting which the nurse teacher had to bridge.

The view of curriculum that Diekelmann (1988) is now arguing somewhat reverses this. The clinical arena becomes a source of primary learning rather than a site for application of theory to practice, and the teacher is present in order to enter into meaningful dialogue with students to facilitate this learning, their experiences thus being brought back to the classroom to enrich and direct their learning experiences there. This is something more than "de-briefing" after clinical, which implies the stripping away of the "extraneous" to ensure that the "important" lessons have been learned, thus remaining teacher-centered. The logistic problems of the number of

students and sites, of course, still remain, but become less troubling if the clinical setting is conceptualized as a place of learning in broader terms than application of theory to practice.

Thus, thinking about nursing knowledge in new ways has implications for how, when, and where learning is planned. To this stage, nursing has followed the dominant schooling model which privileges classroom learning, in line with the Enlightenment tradition with its emphasis on theory as liberating.

This is not to suggest that the problems are nursing's alone--they seem to apply to all practice-based professions. However, they are made more visible within the self-consciousness which accompanies a deliberate striving for professional status as has been apparent in the case of nursing. As an emerging profession like nursing endeavours to model itself on established professions, the lack of fit between its traditional practices and the established framework can make visible the deficiencies of the established framework, particularly if the wholesale abandonment of the occupation's traditional understandings of its world, grounded in practices, is not seen as an option.

The development of medicine as practiced by physicians involved such an abandoment, made possible by the presence of those available to "pick up the pieces." How much medicine has abandoned and is continuing to abandon emerges as a problem for medical educators, among others (Guttentag, 1960). But the central thrust and focus of that discipline as it has evolved militates against piecemeal efforts to reorient it back toward some of the abandoned ground. These

efforts can be regarded as an attempt to build human care and concern back into an increasingly alienated, and alienating, framework. (See, for example, Sullivan, 1986).

Nursing is not yet in that position. Its possibilities lie relatively open at a time in which traditional frameworks for knowledge are coming increasingly into question. It is also an area which has developed predominantly out of the female world and therefore exemplifies many of the issues which feminism has been addressing as it has discovered the obduracy of the male-structured public world. The developing feminist discourse, together with a growing perception of the limits of science as traditionally understood, create a greater space for nursing's development than was available when medicine began its drive toward scientization (or indeed was the case when the first nursing theorists began writing).

Not surprisingly, the nursing literature exhibits some confusion as to what to do with this situated freedom and this continues to be reflected in curricula developed for the preparation of nurses.

CHAPTER II

FORMATION OF MODERN NURSING CONSIDERED AS WOMEN'S WORK

Nobody who has read Florence Nightingale's cri de coeur Cassandra can doubt that "the woman question" lay at the very basis of the foundation of modern nursing. Written in 1852 just prior to commencing nursing and two years before her work in the Crimea, Cassandra is a scorching indictment of the life that the middle-class woman was expected to lead in mid-Victorian England. Nightingale "discovered" nursing as a solution for her problems and went on to establish it as a suitable outlet for the energies of respectable women. That, having found this solution, she then tended to generalize it as "the" solution, does not detract from her vision of opening up for women a field in which their "passion, intellect and moral activity" (Cassandra, p. 1) could be exercised.

Nursing as Part of the Rebellion of 19th Century Women

The evident anger that sears the pages of Cassandra suggests that nursing, as it was shaped in the mid to late nineteenth century, can be fruitfully regarded as a rebellion of middle-class women against their life conditions. Nightingale was not "a voice crying in the wilderness," for, following her leadership, a substantial number of economically comfortable women chose to take off their gloves, to risk damage to their soft white hands, to scour and clean and tend to

patients on the battlefield and in pauper hospitals. (Davidoff, 1976, pp. 126-130, explores the symbolic significance of gloves and small, soft white hands for the Victorian woman.) It seems to have been a rebellion not only against their confinement to the home but against the trivial nature of the "work" that had become their lot within it. While other middle-class women struggled for access to the work of healing on the same terms as men (i.e., the right to become doctors), Nightingale and her followers turned their energies to the development of a feminine alternative, justified in terms of women's traditional concerns. The principles of good housekeeping were to be extended into the public world and the traditional care of women for kin and friends was to be extended to strangers. But the justification tended to obscure the revolutionary nature of the move. A high-status occupation was to be developed in the public world for women, by women--one particularly suited to what were seen as the particular "natural" talents, abilities, and concerns of women.

Precedents, of course, existed. There had been a long history of involvement of middle-class women in nursing through the religious orders. Earlier in the nineteenth century, Elizabeth Fry had sought to recruit "women of character" to be trained to nurse the sick in their homes, although Elizabeth Fry "did not seek to reform hospital nursing, but to learn from its established practices" (Williams, 1980, p. 119). "Women of good character" had also been employed increasingly throughout the nineteenth century as "ward-sisters" or "matrons," at least in the better hospitals. They seem to have been responsible, under the direct control of the doctor, for the

management of the ward and the supervision of the nurses (Williams, 1980). But, as Williams puts it, "there existed no source of nursing knowledge that was external to the sphere of the ward" (Williams, 1980, p. 69). Nevertheless, there had developed, prior to Nightingale, the rudiments of a formalized system of training, and at least a tentative separation of nursing from domestic work.

In contrasting the assessments of a nursing historian with those of a medical historian, Williams argues

> It is not the definition of nursing as a set of practices that has changed, but rather the source of control of those practices in different social arrangements. The ward sister's book at St. Thomas' Hospital represents the first written record of a nurse's practical competence, and it is the elaboration of this "examination" of the nurse as pupil, and of arrangements for examination that were external to the ward, that Miss Breay (the nurse historian) sees as the constitution of a proper conception and control of nursing. The medical historian, as we have seen, rejected these arrangements as leading to "a bad style of nurse," whose knowledge "would not be sufficiently distinct from that of the medical student."
> (Williams, 1980, p. 72)

The early leaders of nursing in the Nightingale era, including Nightingale herself were often of higher social-class origins than the doctors, as Abel-Smith (1960) points out. It seems likely that it was this social-class difference which permitted the setting-up of a source of nursing knowledge external to the ward, that is, outside the direct control of the doctor. The revolt of upper middle-class women thus seems to have been crucial in setting-up nursing as a possible independent occupation, rather than as a straight assistant-to-the-doctor type of role. As developed by Nightingale, nursing was not

simply an attempt by upper middle-class women to enter the public world of nursing work--that had long been open to them as a possibility--but to enter the public world in a particular way, by developing an already existing occupation as an autonomous sphere of work which they, rather than the medical profession, would control.

In some ways and perhaps predictably, the rebellion failed in that it was harnessed and turned to advantage by hospital administrators and by doctors themselves, despite their initial misgivings. Ashley (1976) presents an account that demonstrates how close nurses came to succeeding in creating an autonomous healing profession within the then more open social context of the United States of America. She claims that, even within this more open context, failure was due to the underestimation by nurses of the forces arrayed against them.

> At the inception of organized nursing, nurses in many ways were the equals of physicians in their professional training and their contributions to the health-care of society. However, they were not their equals in the political and economic spheres of human activity ... and it was this lack of equality that would shape their development. (Ashley, 1976, p. 100)

While the formation of nursing as an autonomous occupation was made possible by the involvement of women of high social class, its autonomy was circumscribed by the sexual division of labor which excluded women from positions of power in the political and economic arenas. The possibility of an autonomous nursing occupation was thus created by the social-class division of labor, but negated by the sexual division of labor.

With the benefit of hindsight and from our present perspective, it is possible to see that some of the tactics the nursing leaders adopted were self-defeating. By emphasizing the continuities of "womanly service" across the private and public domains, by justifying their involvement in terms of the "natural" caring role of women, by attempting to defuse the hostility and suspicion of the doctors by emphasizing their supportiveness and helpfulness, they tended to strengthen the sexual division of labor which was turned against them. Yet they were operating within the context of their times, using what was then available to them. O'Neill (1971) traces the failure of social feminism in late nineteenth and early twentieth century United States of America to a similar cause.

> Their entire rationale precluded the attainment of genuine equality. By justifying their activities on the grounds that society was an extension of the home and women's work in it merely an enlargement of her maternal powers, social feminists froze the domestic status quo.... Social feminists wedded their interests as women to their concerns as reformers, little realizing that this made one contingent upon the other. Of course, in the later nineteenth century this strategy seemed the most obvious kind of common sense.
> (O'Neill, 1971, pp. 353-354)

Nursing was thus not alone in unwittingly strengthening the sexual division of labor by its efforts on behalf of women. Even today, similar tensions can be seen within feminism, to the extent that it seeks to retain its hold on values that were nourished in the traditional female world. However, today, a much stronger attack is being mounted on the ontological underpinnings that support the dominant order and relegate the values developed around caring

practices to a subordinate position; see, for example, Keller (1986).

Hoagland (1982) argues that the concept of femininity itself reinterprets acts of female rebellion, being used to obliterate "any conceptual hint of female resistance to male domination, resistance to attempts to limit or control a womon's (sic) integrity" (Hoagland, 1982, p. 89). In just such a way, a "feminized" Nightingale--the "Lady with the Lamp"--was presented to the public imagination, rather than the woman who compiled statistics in novel ways and used them to argue with the War Office in London (Palmer, 1977). Even where the tough Nightingale is presented (as in Strachey's, 1918, account), the concept of "femininity" is still used to denigrate her achievement--she was a frustrated woman, suffering from an excess of penis envy.

To look at nursing as a form of female rebellion situates it within the wider female rebellion that was then occurring in the early women's movement, and encourages us to see women as actively working out their destiny rather than as the products of impersonal social forces (e.g., patriarchy). As Ashley's (1976) account suggests, we need to consider both the actions, ideas, and dreams of the nursing leaders and the way they interacted with the social context. An account of nursing which is overdetermined in terms of social forces, as in Gamarnikow's (1978) account of nursing as sexual division of labor, loses much of the existential reality of nursing. Although nursing was in some sense formally subordinated to medicine, that subordination was never complete. Nursing continued to have access to a body of knowledge at least only partially controlled by doctors. Nursing did not return to its pre-Nightingale state where knowledge

was under the direct control of the doctor.

Much informal subordination also took place, initially justified by the sexual division of labor (as Gamarnikow, 1978, shows) and later by meritocratic criteria--the doctor's assumed superior education and skills. But there was, I would argue, also a continuing resistance to such informal subordination. The citation that Gamarnikow (1978) uses to demonstrate the sexual division of labor between doctors and nurses can be viewed from a different perspective by asking why it was necessary to remind early twentieth century nurses so often of their subordination in terms so redolent of ideal Victorian male-female relationships. Asking this question suggests the presence of a continuing nursing resistance to subordination at the informal level of day-to-day interaction.

Stein (1971) has cogently explored what he calls the doctor-nurse game, whereby nurses "set up" diagnoses, investigations, and treatment modalities for doctors while maintaining the fiction of doctor as sole decision-maker. But experience suggests that an equally interesting game exists whereby nurses make life exceedingly uncomfortable for those doctors who fail to pay due respect to the knowledge and skills of the nurse. Like the woman who burns the dinner whenever her husband has important guests (Hoagland, 1982, pp. 89-90), some tactics used run the risk of being labelled "incompetence," thus reinforcing feminine stereotypes. A decision, for example, by nurses whose competence has been impugned to continually interrupt the offender's working day and sleep at night with reports of minute changes in the condition of his patients is extremely likely to backfire, however

satisfying it may be. More useful are the asides intended to be overheard, the "naive" questions which expose ignorance, the delegation of the most junior nurse to do "rounds" with the offender and similar tactics.

There is, of course, nothing unique to nursing in such tactics--they have commonalities with tactics used in other situations by the oppressed against the oppressor. But they can be regarded as evidence of a continuing grassroots resistance to subordination which rumbles on, the more public part of which is the struggle in the legal, political, and economic arenas to achieve recognition of nursing autonomy.

Nursing was thus very much a part of the wider middle-class female revolt. But, in nursing, the revolt took the form of establishing in a very strong form the claims of a separate sphere of women's knowledge and skills to which women had primary access. While such a claim provided the basis for its subordination in accordance with the powerfully operating sexual division of labor, it also provided the basis for continuing struggle by separating nursing knowledge from medical knowledge, and it was this move which was seen as most threatening by the developing medical profession, as Williams (1980) points out.

In order to understand more clearly the particular configuration that the nursing revolution took, we need now to turn to consideration of the circumstances against which the early leaders of nursing were revolting.

The Roots of the Rebellion

Barnard (1974) traces the separation of production out of the household during the industrial revolution, as the mill and factory developed. This development gradually stripped the household of both its work and its workers, and divided the two roles of women. Whereas previously the woman's role of care and maintenance of the household and children had taken place intertwined with her role in the production of household goods for use, exchange or sale, the latter was increasingly moved out of the home geographically and economically. While initially working-class women were employed along with their children (thus allowing some continuing combination of the roles), eventually the work was seen as inappropriate for children, and therefore mothers accompanied by children, although the employment of the unencumbered female continued for a long time and, among the poor, virtually never disappeared completely.

Stacey (1981) argues that the separation into a public domain of government and the marketplace and a private domain "where social relations are based on family and kin, on mating, marriage and procreation" (p. 173) actually began earlier with the development of the state which preceded the industrial revolution--the state being the realm of government, from which women were excluded once government started to shift out of the control of kin relationships. While working-class women moved into the marketplace and became a highly exploited portion of the industrial proletariat, as Barnard (1974) argues, the middle-class woman was left presiding over a household which was increasingly losing both its productive work and

workers.

It seems fair enough to see the private domain as a residual one, the repository of work and human needs for which no provision has yet been made in the marketplace economy. As work was increasingly identified with paid labor in the marketplace and home came to be seen as a place to relax from "work," there was a tendency not to see the work (and the workers) who remained in the home. This was most markedly the case where their labor was unpaid.

The industrial revolution thus sharpened the sexual division of labor, and this was most markedly the case initially for middle-class women, although the wife "who did not have to work" increasingly also became the goal of at least the upwardly mobile working-class. Warren argues that "this sharpening of the sexual division of labor coincided with the appearance of new popular and philosophical rationalizations of that sexual division" (Warren, 1982, p. 172). Whereas previously philosophical rationalizations of women's inferiority were in terms of her "natural" mental and physical inferiority or her moral inferiority (Eve's sin), as women, especially middle-class women, were relegated to unpaid domestic labor, they were assigned the task of providing emotional support for their husbands and children--they were expected to fill the deficits of the impersonal public domain. This role was justified on the basis that they "possessed special intuitive and expressive capacities that men lacked" (Warren, 1982, p. 172).

In some ways, this could be seen as an improvement for such women, since they were now being granted at least some qualities in which they were superior to the male, and we should not be surprised

that such women increasingly elaborated such perceived superior qualities--the conditions of their work requiring, moreover, that they do so. But the price was a heavy one, as those very qualities operated to further cut them off from the public domain where other "virtues" prevailed--virtues which were associated with paid and therefore useful labor, and which were seen to be increasingly the province of men.

But pure expressiveness, I would argue, is an elusive (and probably illusive) goal. Davidoff (1976) describes the increasing elaboration of housework that occurred during the eighteenth and nineteenth centuries. (Elsewhere, Aries, 1962, has described the elaboration of childcare.) She argues that this elaboration was a product of concern with boundary-maintenance at a time when class barriers became increasingly permeable. But it could also be seen as an attempt by women to develop the work that had been left to them as a vehicle for expressing the care and concern that the new "femininity" demanded of them. (This is not to exclude the possibility that such work also became an end in itself--a replacement for the work in which they had previously been involved.) But no matter how elaborated, this work remained unpaid (at least for the mistress of the house) and unseen (since boundary maintenance is more visible in its absence than presence).

Among the wealthy middle-class, the work of the mistress or daughter of the house was further attenuated as most boundary-maintenance work was relegated to domestic servants. Even supervision of such servants was often delegated to a housekeeper.

Davidoff (1976) notes the increasing use of domestic servants and the increasingly complex division of labor in the home. Within this context, "leisured" women created work out of such things as the paying and receiving of visits, to the extent that balance sheets were kept! (Davidoff, 1976, p. 136).

In the context of Davidoff's description of housework as boundary-maintenance--the separation of the raw from the cooked, the unclean from the clean--and its association with subordination because those who do it come into contact with the ritually "impure"--it is not hard to see why women who could afford to do so delegated those tasks to someone else. Such delegation extended also to childcare, for children are unsocialized and thus "uncivilized" forces (Davidoff, 1976, p. 125). But the price to be paid for such delegation was that of increasingly meaningless ways of occupying one's time. Invalidism was one solution (Ehrenreich & English, 1974) and an extreme elaboration of social life was another, but to at least some women such pursuits appeared empty. It is, indeed, just such pursuits that Nightingale so trenchantly attacks in Cassandra.

Of course, not all middle-class women were so "fortunately" placed. For many, the struggle to keep up appearances involved them in varying degrees of physical labor to compensate for fewer servants (Davidoff, 1976). In addition, the unmarried "genteel poor" frequently had to take upper-servant positions in middle-class homes as governesses, nurses or nannies, their conditions of work and status acknowledgment highly dependent on the whims of their employer.

But it is significant that the rebellion which gave rise to

nursing was led by upper middle-class women--those who ostensibly had most benefitted from the class system that relegated work to others. For them had been created a life as close to pure affect as it is possible to get. Yet Nightingale clearly saw the withering of "passion" that its separation from action and thought had produced.

> They [women] are exhausted, like those who live on opium or on novels, all their lives--exhausted with feelings that lead to no action. If they see and enter into a continuous line of action, with a full and interesting life, with training constantly kept up to the occupation, occupation constantly testing the training--it is the beau-ideal of practical, not theoretical, education--they are re-tempered, their life is filled, they have found their work, and the means to do it. (Nightingale, 1852, 1971, p. 41)

Her answer was not the rejection of feeling, but its revivifying by relinking it with thought and action in a very practical way. In her thinking here, we can see the beginnings of a conceptualization of nursing as a high-status, useful, public occupation. (She had previously rejected "the family" as "too narrow a field for the development of the immortal spirit" (p. 37) and the vacuous intellectual activities of social life.)

The Development of Nursing

The development of the occupation of nursing required drawing on material already available and there were marked continuities between the traditional role of women within the private domain and the new occupation of nursing, as Gamarnikow (1978) demonstrates. There were also marked continuities with the occupation of nursing as it had previously existed (Williams, 1980). But there were also marked

discontinuities. The new occupation was seen as demanding knowledge and skill for which training was necessary--socialization as a woman was no longer enough. More importantly, the knowledge and skill required was seen as existing, at least in some sense, independently of medicine, and certainly of individual doctors. On this basis, it staked its claim for public recognition as a high-status occupation. Related to this claim, it also established a possible career for women (as Melosh, 1982, p. 27, points out), since once knowledge and skill are recognized, the possibility of advancement on the grounds of education and/or experience becomes a possibility. The caste-like statuses of matron, sister, and nurse became transformed into a hierarchy of skills through which progression was possible.

I have used the term "occupation" advisedly, because there was considerable disagreement about the nature of the occupation. Within the United States context, Melosh (1982, pp. 15-35) examines the dispute as to whether it was a "vocation" or a "profession." In broad terms, she sees those who saw it as a vocation as the ones who stressed its continuity with the private domain of the home, while those who stressed the occupationally acquired skills and knowledge saw it as a profession. I cannot agree with her in equating this difference with shop-culture versus leadership, since it is predominantly the leadership that have left the written records on which she relies for her argument (grassroots nurses do not write textbooks or letters to journals). Nevertheless, there does seem to have been a real division of opinion within the leadership, which is not surprising, given their middle-class origins. The leadership had

been inducted into the ethic of womanly service and also been exposed to professional models within the public world. I suspect that the division of opinion may have existed even within the individual leaders themselves, that is, that there was considerable ambivalence. My reason for this suspicion is my experience with the debate on the future of nurse education in Australia, where the issues Melosh discusses have been re-played among the leadership in public forums and private conversations, the latter being particularly revealing of the ambivalence.

Be that as it may, significantly, although not unexpectedly in view of its upper middle-class leadership, few if any saw the occupation as a skilled trade or "just a job." While such conceptions may have been present at the grassroots level, they have not survived in the literature, except indirectly as expression of what nursing is not. Melosh, for example, cites the following from a 1922 text on public health nursing by Annie Brainard.

> Nursing is not merely a profession--it is a vocation, not merely a gainful occupation, but a ministry. (Melosh, 1982, p. 23)

Statements such as this seem to have been produced as much for an internal as an external audience, and suggest the presence within the occupation of those who did see nursing primarily as just a way of making a living. Even today, nursing leaders continue to rail against "washing-machine nurses"--those who are perceived as insufficiently committed to nursing itself, who are seen as nursing simply to supplement household income. While I believe this is a misreading of the situation of many married nurses, since the power of the ideology

nursing has developed makes it very difficult to treat as "just a job," it may well have been more marked at an earlier stage of development of the ideology.

It seems very likely that many of the "genteel poor" embraced nursing as a respectable way of earning a living, once it was made respectable by the presence of upper middle-class women, and that their attitude may have been a more pragmatic one. For them, it must have offered a more dependable structure with some opportunity, however limited, for upward mobility. The heavy loss to the occupation through marriage is also suggestive of a more pragmatic stance on the part of a considerable portion of the nursing work force.

The early structure of the Nightingale training-system in England still reflected class differences. It drew a distinction between "lady pupils" who paid for their training and "probationers" who were given board and uniform and sometimes a small stipend during training (Abel-Smith, 1960, pp. 17-35). The latter permitted the entry of the "genteel poor" and upwardly mobile working-class women, but at the cost of undercutting its professional claims, since skills and knowledge one attains by paying for assume a higher value. Initially the "lady probationers" could expect better prospects on completion of training, but with the rapid expansion of trained nursing, this basically unstable distinction broke down (unstable since both groups went through the same training and attained the same qualifications). The breakdown was in favor of the probationer plan because of the rising demand for nurses, which could not be met by "lady-pupils"

alone, and the usefulness of the probationer scheme to the developing hospitals. This will be examined in more detail in the next section.

There are many parallels between the development of nursing and the development of medicine, as explored by Sadler (1978). The leadership of both occupations lay with the upper middle-class (in the case of medicine, it was the liberally-educated physicians). The dispute as to whether nursing was a "vocation" or "profession" had its parallel in the debate as to whether medicine was an "art" or a "science" (Sadler, 1980). The expansion of the market for medical care with the growth of the middle-class required the incorporation within the profession of lower-status practitioners (barber-surgeons), just as the expansion of the market for trained nurses required the incorporation of practitioners of lower social standing. The ambiguous victory of science over art within medicine is paralleled by the ambiguous victory of the concept of a profession over that of a vocation within nursing.

But the development of medicine as a profession had begun much earlier and was already entrenched by the time women made their bid for a female healing occupation. The upper middle-class physicians had already absorbed the barber-surgeons and gained control of the apothecaries. Pre-Nightingale nursing was already constituted under the individualized control of doctors (as Williams, 1980, argues). Moreover, upper middle-class females did not have the direct access to the political and economic arena that physicians enjoyed, and the public domain as a whole was seen as one in which women were "naturally" subordinate to men. Given the ways in which the cards

were stacked against them, the achievement was a remarkable one. Although there are a number of aspects of this achievement, a very important and perhaps the central one, as Williams (1980) argues, was the opening up of the possibility of developing traditional female healing knowledge within the public domain, outside the control of the doctor. This set the stage for the continuing struggle by nursing to maintain control of its knowledge base against the continuing efforts of established medicine to incorporate them as assistants--to teach the nurse "all she needs to know" themselves.

Role of the Developing Hospital

The development of nursing under the leadership of upper middle-class women coincided with a change in the role of the hospital itself, as Abel-Smith (1960, p. 20) points out. The hospital was gradually changing from a storage-area for the indigent sick (scarcely distinguishable from the pauper-house) to the curative institution we know today. This change was closely related to the change in the nature and source of medical knowledge, as Foucault (1973) points out. As the focus of medicine changed from seeing disease as the result of imbalances in the humors to locating it within the organs of the human body, a different type of generalization about disease became possible and, indeed, rose to prominence. As Sadler (1978, pp. 188-189) points out, the belief in organ-centered disease entities that existed independently of the individual gave a new medical significance to the pooling of a mass of sick people. The hospital thus became a privileged site for the development of medical knowledge.

Within this context, the sick gained a new importance somewhat independent of their social-class origins, although it was originally the paupers in the pauper-hospital who provided the material for the development of medical science, which was then used by the doctors to treat their middle-class clientele. The moves to reform the hospital from the late eighteenth century on can be understood within the context of the need to develop a better-organized "laboratory" for medical science. While there were undoubtedly more humanitarian motives, the form the reorganization took was highly consonant with the needs of medical science for grouping of patients as disease-entities. However, it is only with the change to smaller rooms to replace open wards that the final rationalization has been accomplished--the obliteration of the male-female distinction except where it pertains to a medical specialty.

Along with the need to reorganize the hospital, there developed a need for close observation of pauper-patients, for they were now seen as being able to yield up the secrets of disease processes. Intervention, too, required increasingly close monitoring to judge its effectiveness and to compare different treatment modalities. Unless one was to endlessly expand the supply of medical students and therefore doctors, the medical profession needed nurses, although not quite the type that the Nightingale revolution produced.

The resistance to the Nightingale revolution among doctors was based on the belief that they already had the pattern for the nurses they needed. Enough middle-class women had already taken up positions as "sisters" to reorganize the wards of at least the major teaching

hospitals in accord with their middle-class socialization into organization of the home. Doctors could pass on to the ward-sister the knowledge needed for the sort of observations and care that the doctor required, the ward-sister then being able to mediate this knowledge as required to the nurses. This is the picture that emerges from Williams' (1980) account.

Why, then, did the revolution occur? Interacting with factors such as nursing's high status leadership with links to powerful philanthropists and the impetus derived from the frustrations of the established female middle-class lifestyle, were the needs of those charged with running the hospitals. Although the hospitals were becoming an important locus of medical knowledge, they were still being run and financed as charities. The availability of suitable women who were prepared to work for marginal or no returns under the guise of training was a very attractive one, as Ashley (1976) points out, within the United States context. While the original pattern at St. Thomas' Hospital was for an independently financed "school" separate from the hospital, but using its facilities, this was possible only because of the presence of the Florence Nightingale Fund--monies subscribed by a grateful public in the wake of Nightingale's widely publicized work in the Crimea (Abel-Smith, 1960). As is well know, when the pattern was copied elsewhere, it was without this financial independence, and nurse-training became a cheap way of staffing the financially hard-pressed hospitals.

The interests of the hospital administration thus diverged from the interests of the doctors. The hospital administrators were less

interested in the control of knowledge than in the inexpensive running of the hospital. In this way, the new nursing meshed closely with the interests of those who ran the hospitals. A similar situation can be seen in Australia today, where the Australian Hospitals Association is now supporting the movement of nursing education out of the hospital (because of the huge financial burden it has come to be), while the Australian Medical Association remains adamantly opposed.

But while the Nightingale revolution had given nursing "a foot in the door" as far as the development of an independent occupation with its own body of knowledge was concerned, many factors operated against its elaboration, which we will now turn to examine.

Early Shaping of Nursing Knowledge

Since knowledge tends to develop out of what is already available to us, I shall take it that the starting point for the development of nursing knowledge came out of the middle-class home, with its concerns for boundary-maintenance (Davidoff, 1976) and care of others. Sexual prejudice aside, there seems no reason to suppose that these matters provided a less appropriate field for inquiry than any other.

But the Nightingale revolution chose the same primary locus for knowledge as the medical profession had--the hospital. The hospital, however, was already being organized in terms of the priorities of medical knowledge. Even so, within the large Nightingale ward it was possible to at least partially organize patients according to nursing care priorities--an ability which has been increasingly lost with the demise of the Nightingale ward. Nevertheless, any nursing

organization had to be within the parameters of the pre-existing medical organization. Thus, within the hospital, organization of nursing knowledge tended to fall within the ambit of medical knowledge organization--a position from which it is still struggling to extricate itself today.

Moreover, there was a basic consonance between the way medicine was organizing disease entities and the broader structures of society. While, as Wright and Treacher (1982, p. 10) argue, it is simplistic to claim that medicine is a simple and direct reflection of some kind of social base (because of the tendency of bodies of knowledge to take on a dynamic of their own), it does arise in the social base. The tendency for medicine to locate disease within subparts of the human organism was thus highly consonant with the way the industrial system had broken down the work process. Nursing, to the extent that it endeavoured to emphasize the environment and the individual as whole person ran counter to these trends.

Medicine had also allied itself strongly with the dominant scientifico-technical mode. As Sadler (1978) points out, this only came about after a long and protracted battle with the physicians, who claimed that medicine was an art, for which a liberal education was the best preparation. But, as she argues, "standards of legitimacy of what constituted knowledge within society as a whole changed with developments of the industrial revolution" (Sadler, 1978, p. 185). Nursing, however, was emerging from the private domain, marginalized by the industrial revolution, and was less penetrated by the new concept of knowledge. There was thus a tendency to continue to view

nursing as an art, as the early physicians had viewed medicine.

There was also a problem of social class. The way that medicine created disease entitites located in body organs made the knowledge attained in the pauper-hospitals readily transferable to private practice. While this directly benefitted individual doctors, it also benefitted the medical profession as a whole because it ensured that funding was forthcoming for further refinement of a body of knowledge that could so directly assist the wealthy as well as the poor. The usefulness of nursing was not so directly apparent, possibly because the middle-class already enjoyed a high standard of boundary-maintenance and personalized care within their own homes. In this, nursing suffered the same poverty of funding as public health.

Although the initial exclusion of nursing from the universities was also a factor, it is apparent that there are problems beyond simple exclusion from the university, as the American experience has demonstrated. As Davies (1980) points out, the same factors that have operated in Britain to ensure the exclusion of nursing from the universities have operated to ensure that nursing remains an underfunded and therefore marginal part of the American university.

Nurses, in their attempts to follow up the "foot in the door" opportunity provided by the Nightingale revolution to develop their own conceptual base, have thus been endeavouring to operate from a position of weakness. In a context ordered by the priorities of medical knowledge, with a world view deviating from the dominant one formed in the public domain, confined to the less financially-rewarding aspects of healing and thus underfunded, they have had much

more than being women to contend with. Yet their problems have their origin in the problematic conception of a female profession, in the idea that a mode of operation which made sense within the private domain could be transferred without undue problems to the public domain.

CHAPTER III

THE ENDEAVOURS TO DEVELOP NURSING AS A SCIENCE

In the previous chapter, I argued that middle-class women in moving into nursing, attempted to transfer into the public world of the hospital and health care the elaboration of both housework and personal care which had occurred within the middle-class home that had been cut off from the wider public world. The elaboration of housework translated itself into a concern with the environment which was both physical and moral (because of the close connection between cleanliness and morality in nineteenth century thought, as described by Davidoff, 1976). The elaboration of personal care, in translation from care of kin to care of strangers, tended to focus on the individuality of the patient. Nurse were encouraged to conceptualize patients in terms of "possible kin" and to thus relate in a personalized way to them. Both strands continue to weave their way through nursing knowledge today.

To the extent that nursing was interested in extending "good housekeeping" into the public domain, it found natural allies within the public health movement. To the extent that it focused on individual care, it was in line with the individualized accounts of illness which were developing in the medical model. This states the case rather too baldly, since Dean and Bolton (1980) demonstrate how nursing became the individualized arm of the public health movement (the one directed at individuals, homes, and families) and, within the

hospital, the germ theory of disease provided scientific support for at least some elements of good housekeeping, directing attention to at least the immediate environment of the patient. Nursing could thus complement both the public health movement and individualized medicine, particularly as it was practiced within the hospital. Its broad range of possible interests and actual functions made it somewhat amorphous and difficult to define, particularly in the light of its tendency to take up the slack--"to do in a responsible way whatever necessary things are in danger of not being done at all" (Everitt Hughes, 1971)--again demonstrating its continuity with the role of women within the private domain (Stacey, 1981).

Origins of Nursing Theory

Despite the claims that Nightingale's Notes on Nursing was the origin of nursing theory, nursing remained for some time an area of knowledge which relied on a fairly unsystematic rough empiricism. Indeed, Nightingale's Notes on Nursing can itself be regarded largely in this light, having more in common with nineteenth century housekeeping manuals than with scientific texts, and the fact that it was addressed to the same audience is often overlooked. Although Nightingale argued for the importance of training in nursing, her "beau ideal" was "of practical, not theoretical, education" (Nightingale, 1852, 1979, p. 41), one in which knowledge would arise and be refined by testing in practice.

While, in some sense, early attempts to define nursing could be seen as the genesis of formal model development and thus as

predecessors of theory (Hawkins, 1983), such a view tends to be revisionist in projecting the present back into the past. The idea that one could formalize nursing knowledge as a science seems to have been a very recent development, and even the identification of Peplau (1952), Henderson (1966), Wiedenbach (1964), and Hall (1966) as nursing theorists seems to involve a certain level of revisionism, although less marked than in the case of Nightingale. In their review of nursing research, Gortner and Nahm (1977) demonstrate that, at least until 1965, nursing research tended to be involved overwhelmingly with immediate practical problems (in accord with a rough empiricism).

Nevertheless, it is probably reasonable enough to claim that there was during the 1950s and 1960s a growing move to formalize a body of nursing knowledge out of this rough empiricism, at least within the United States context. But until fairly recently, other countries seemed to have been more inclined to stay with the rough empiricism. (By referring to it in this way, I do not intend to denigrate such knowledge. It is, after all, an important means of getting around in the world and, at its best, it can be excellent indeed, as in the case of the Amati family being able to produce violins that are so far unmatched by modern science.)

There has been recent evidence in the nursing literature of an interest in developing a history of nursing theory as it has occurred in the United States context, although much of it is revisionist in the way described above. Some articles, like that of Newman (1983) are concerned primarily with history, while others include history as

part of a larger discussion of theory (Chinn, 1983; Chinn & Jacobs, 1983; Fitzpatrick & Whall, 1983; Hardy, 1983; Hawkins, 1983; Silva & Rothbart, 1983; Thibodeau, 1983; Walker, 1983).

While Florence Nightingale is discussed by almost all the mentioned writers as the founder of nursing theory, most writers move immediately from her to Hildegarde Peplau in 1952, who is seen as the first modern theorist. Hawkins (1983) is an exception in tracing the continuity of the "metaparadigm" laid down by Nightingale through the writings of Shaw, Robb, Harmer, Dock and Stewart, Frederick and Northam, although she agrees with the others that Peplau marks the beginning in this century to establish a scientific base for nursing.

Various factors are seen as contributing to the impetus to develop theory. Newman (1983) identifies the quest for professional licensure, with its concomitant need to distinguish nursing practice from medical practice. Chinn (1983) sees the impetus for serious development of nursing's conceptual base as arising out of the integration of nursing education into institutions of higher learning and the consequent demand for research and scholarship. Meleis (1983a) mentions the need for a sound conceptual basis for developing alternatives to the medical model curriculum as an early factor. (An associated curriculum factor was the need to integrate psychiatric nursing into the nursing mainstream in the 1950s.) Silva and Rothbart (1983) see the Nurse Scientist program during the 1960s as an important influence, although Martha Rogers (interviewed in Safier, 1977) is less impressed by its contribution. It is clear, however, that by the time of the three nursing theory conferences (1968-1970),

there were a number of people who were struggling very self-consciously with what had become defined as the problem of nursing theory.

Chinn and Jacobs (1983) take a somewhat broader view, relating the development of nursing theory to the changing status of women, interacting with factors within nursing itself. Silva and Rothbart (1983) discuss the influence of a changing philosophy of science on the way nursing theory is regarded, although they see a continuing gap between theoretical and metatheoretical developments, the latter being more strongly influenced by the emergent view of science as socio-historically constructed, rather than the discovery of facts about the world.

An English writer, Celia Davies (1982), in contrasting nursing developments in Britain and the U.S.A., discusses the role of public health nursing, with its relatively greater individual autonomy for the nurse, as a factor strongly influencing the direction of American nursing. The greater sense of individual autonomy, together with the more open university structure within the United States (in comparison with Britain) which allowed nursing to become established within the universities, nurtured the idea of nursing as an independent discipline in a way that the British system did not.

Although all the factors noted are partially explanatory, some, like the need for curriculum development, the integration of psychiatric nursing, and the role of public health nursing, are more explanatory of the particular shape that nursing theory took. That it took shape at all seems to be best explained by the entry into the universities and the subsequent perceived need to justify its position

in terms of research and scholarship, as Chinn (1983) argues. Interest in formal nursing theory seems much less marked in countries where nursing is outside, or only marginally within, the university context.

Perhaps the most puzzling thing is the shape of nursing theory--the belief that one could build a conceptual framework that would be all-embracing, that would explain the whole of nursing. While this view has more recently been subjected to criticism (Meleis, 1983a, for example), it was, for some time, a prevailing orthodoxy. There seemed to have been a belief that there was an essence of nursing that was independent of its setting. This belief lingers on in recent attempts to construct nursing as a "science of caring" which will be dealt with in the next chapter. This idea may have had its roots in the attempt to develop theory as a basis for orderly curriculum development, that is, in the attempt to prepare nurses for a wide range of settings and eventualities. (The connection between knowledge development and curriculum development is explored in Chapter VII.)

But the attempt to pin down the essence of nursing meant that nursing theory had to cover such a broad range of situations and possibilities that it ended up saying very little about the real world. Thus, although recent metatheoretical writers (Chinn, 1983; Flaskerud & Halloran, 1980; Newman, 1983) have rejoiced in finding a "metaparadigm" underlying nursing theory, the "metaparadigm"--human beings, environment, nursing and health--simply exhibits in a more extreme form the problems that the attempt to be universal imposed on nursing theory itself. While the so-called metaparadigm seems to have

an air of truth about it (all the more so by being traced back to Nightingale), it is a spurious sort of truth, without focus or guidance. It could include anything and everything--virtually nothing is excluded.

Nursing Research

Although nursing research does not ostensibly aim at such universality, recent reviews and discussions (Abdellah, 1977; Batey, 1977; Brown, Tanner, & Padrick,, 1984; de Tornyay, 1977; Gortner, 1980a, 1980b; Gortner & Nahm, 1977; Schlotfeldt, 1977) also reveal a very wide range of concerns which tend to be expanding further, rather than narrowing down and focusing on distinct, identifiable, nursing entities. This shot-gun approach seems to be due to efforts to solve immediate, visible problems in the context of a very amorphous occupation, rather than to develop a coherent body of knowledge as such. Gortner and Nahm (1977) provide a comprehensive historical overview of nursing research, considering developments within the context of changing priorities in nursing and health care. Early concerns with hygiene and sanitation, medical and surgical asepsis, gave way in the early post World War II period to concerns with recruitment, preparation, and retention of sufficient numbers of nursing personnel. The dominance of educational and administrative research in 1955-1965 gave way in turn to an expansion of clinical studies, continuing to this day. Apart from the apparent paucity of administrative research (which may at least partially reflect the journals chosen for study), Brown, Tanner, and Padrick's (1984)

analysis of nursing research since 1952 is in general agreement with Gortner and Nahm.

In the context of discussing the U.S. Public Health Services' contribution to nursing research, Abdellah (1977) identifies a developmental period (1955-1968), a clinical nursing period (1969-1972), and an outcomes of nursing care period (1973-1976), but this may reflect more the policies of a particular funding authority than the actual state of nursing research.

McConnell and Duffey (1978) reviewed research published in the journal Nursing Research 1970-1975. Over this period, they found no increase in nursing practice studies, defined as studies that dealt in any way with nurse/patient (client) interaction. They noted a relative paucity of studies dealing with the physical aspects of care in any way--only 11 such in that period compared different techniques for physical care. Smallness of sample size, lack of replication, and lack of concern with the validity and reliability of instruments were some of the other problems noted.

In reviewing all research reports in Nursing Research since it was first published in 1952, Batey (1977) noted a considerable increase in sophistication, particularly in the area of methodology, but saw a continuing problem in inadequate conceptualization of the research problem and inappropriate interpretation of results. More recently, Brown, Tanner, and Padrick (1984) document the relative absence of conceptual perspectives from the research literature (even using a very broad definition of conceptualization), although the situation has been improving. It is clear from their discussion that

most of the conceptualization used is drawn from related disciplines, rather than from nursing itself--theory in nursing rather than theory of nursing (Ellis, 1968).

There seems to be considerable evidence to support Gortner's contention.

> An onlooker might characterize most nursing investigations as discrete, non-aggregated studies of empirical phenomena for which the underlying science or explanatory theory is not known or not yet well-developed. (Gortner, 1980b, p. 205)

Nevertheless, Schlotfeldt (1977) argues that there is now general agreement on the appropriate focus of nursing research, it being concerned with

> Advancing knowledge concerning the health-seeking behaviours (mechanisms) available to generic man and a discovery of strategies effective in sustaining and augmenting them. (p. 6)

If this is so, then it may be that nursing theory and nursing research have at least arrived at the same ballpark, although the game is yet to be played. This contrasts with research's preoccupation with education and administration delineated by Gortner and Nahm (1977) while nursing theory was initially developing (from 1953 on). But the ballpark is still very global.

Nursing as a Form of "Ecology"

The academic discipline of nursing as it has developed in the United States of America could perhaps be conceptualized as an endeavour to create a science of human ecology in relation to health. As a type of human ecology, it can be distinguished from the

discipline of public health, which has a somewhat similar interest, by the tendency for its concern to move outward from the individual rather than inward from the population--a concern dictated by the nursing portion of the "metaparadigm" with its emphasis on the nurse-patient (nurse-client) relationship.

If conceptualized as a developing ecological science, nursing's concern can be seen as lying with the interconnectedness and relatedness of events in the biological, psychological, and social realms as they relate to the individual or group in need of nursing care and with the tracing of such patterns of interconnectedness. But just stating it in this way relies on an implicit understanding of what the "nursing care" is of which individuals or groups are in need, for it is only this that distinguishes it from other possible ecological sciences. Moreover, one needs to specify more clearly the environment-is it the internal environment or the external, and, if the latter, is it the micro-environment or the macro-environment? I will turn to these questions later, when I discuss the problematics of nursing's identified "metaparadigm," but concern with the environment has obvious continuities with the "housekeeping" concerns that nursing leaders generalized out of the middle-class home.

The other major strand--the generalization of the care women had traditionally taken of kin to the care of strangers--lies implicitly included within the nursing portion of the "metaparadigm." It can only be such implicit inclusion which allows the "metaparadigm" to embrace the writings, in particular, of the interaction theorists (Peplau, Orlando, Wiedenbach, Travelbee, Paterson & Zderad, for

example). It is also implicit, perhaps, in "human beings" who are assumed to have certain needs that can be met by the nurse. The ethic of care for those in need can be related to what Gilligan (1982) found to be the central concern of female moral consciousness as it has developed in a dichotomized society--a responsibility to do something about the real and recognizable trouble of the world. As Gilligan's research reveals, it is generally a bounded form of care which addresses itself to an adjudication of competing claims of known individuals, rather than addressing itself to the wider world.

Linkage Between Theory, Research and Practice

While nursing theory originally developed as a means of curriculum organization that would provide an alternative to the medical model (Meleis, 1983a), it was soon conceptualized as providing a scientific basis for a practice discipline (Dickoff & James, 1968a, 1968b) which, it was hoped, would provide an increasingly rich understanding of the patterning of human health on which more effective nursing interventions could be based. The developing body of clinical research in nursing is also directed toward this end. Thus, in conceptualization at least, nursing theory, research, and practice should be integrally linked.

In the real world, the links have proved elusive. Nursing theory has been seen as inadequately researched (Chinn & Jacobs, 1983; Meleis, 1983a) and nursing research as inadequately conceptualized (Batey, 1977; Downs, 1983; Gortner, 1980). The prescriptive theory for practice envisioned by Dickoff and James (1968) has, by and large,

failed to emerge (Walker, 1983). While some research has provided guidance for practice, the area as a whole has consisted of piecemeal, unreplicated studies (Gortner, 1980), inadequately conceptualized (Batey, 1977), and therefore difficult to link together in sound theoretical base. What Fawcett (1978) characterizes as "the double helix" between theory and research has thus failed to develop.

At the same time, significant barriers have existed between nursing scholarship and nursing practice (Chinn, 1983; Hardy, 1983; Walker, 1983). While nursing's historical anti-intellectualism may be one factor, as Chinn (1983) suggests, there are obviously others that relate to the difficulty of perceiving the relevance for practice of much nursing scholarship as it has so far developed.

This is not to argue that all scholarly work should have immediate practical application, but that, given nursing's conceptual linkage of theory, research, and practice as outlined above, we need to be concerned about the continuing elusiveness of the links.

Reappraisal of Nursing Theory

Within this context, a re-examination of the development of nursing theory seems appropriate. As Walker (1983, p. 410) argues,

> Growth requires reflection, sometimes painful, upon what one is about. In contrast, nursing theories have often been accepted or adopted in uncritical ways. The careful and critical scrutiny of ideas ... has largely been bypassed in incorporating nursing theories as frameworks for research, practice and curricula in nursing.

With this in mind, I will turn to examine the four aspects of the accepted "metaparadigm" as a way of looking at the problematics of

nursing knowledge. In doing so, I will use the grouping of nursing theorists suggested by Meleis (1983b), i.e.,

1. Humanist/interactionist theorists: Peplau (1952), Orlando (1961), Wiedenbach (1964), Travelbee (1971), and Paterson and Zderad (1976).

2. Deficit theorists: Henderson (1960, 1966), Abdellah (1960, 1969), and Orem (1980).

3. Conservation/Adaptation theorists: Levine (1967, 1973), Roy (1974, 1980), Neumann (1974, 1980), and Johnson (1974, 1980).

4. Homeodynamic theorists: Rogers (1971, 1980), Newman (1979), Parse (1981), and Fitzpatrick (1983).

Any system of classification presents problems with areas of overlap and involves some degree of unfairness to the complexity of the ideas developed. However, it also provides a way of ordering and dealing with the phenomena. King (1971, 1981) is hard to classify but probably warrants including in the adaptation/conservation approach because of her use of systems theory. The "science of caring" theorists, Watson (1979) and Leininger (1978) can be seen as a variant of the humanist/interactionist approach, with their roots in Wiedenbach (1964) and her emphasis on the helping process, but I will deal with the "science of caring" approach in more detail in the following chapter.

Human Beings

The ascendant medical model constituted sick human beings largely as "machines gone wrong." It thus directed its attention to the

detailed workings of the machine, situating disease in organs, parts of organs, cells, and within the cell itself. Increasingly, the rough empiricism that had earlier characterized medicine was replaced by an increasingly accurate targetting in on "the defective part." Any deficiencies of this approach were seen in terms of the sheer complexity of the machine (which, unlike other machines, was not constructed by man, so that the blueprint had to be constructed in reverse--from the machine to the drawing-board). Defective parts were removed (if "non-vital") or targetted by pharmacological intervention. More recently, vital defective parts have been replaced by nondefective parts from another "machine" or by man-made replacements.

While other models of the human being continued to exist "on the fringes," man-the-machine dominated medical research and funding, as, indeed, it still does, although its shortcomings are becoming more apparent. Access to this concept of human beings for nurses was largely only available through subordination to the doctor who had gained legal control of the means of intervention in the machine through control of pharmacology and surgery. The human being was equated with the human body and constituted by medical discourse as the passive object of knowledge (Armstrong, 1982).

Armstrong (1982) argues that medical discourse began to change slowly in the 1930s, initially through the conceptualization of the "defaulter." This marked the beginning within the discourse of medicine of a more active view of the patient as "subject." On his account, the constitution of the patient as active subject is the product of mid-twentieth century medical discourse. Yet, if we follow

Dean and Bolton's (1980) argument that nursing practice emerged in the nineteenth century as a technique for management of the sick poor, we can trace an earlier beginning of the active subject discourse with the broader domain of medicine generally, including nursing and public health.

To the extent that the nurse was expected to teach the poor to be clean and orderly, to care for their sick and preserve their family unit from being broken up (Dean & Bolton, 1980, p. 95), she probably had to begin to constitute an active subject, even if in a very rudimentary fashion. Nightingale's Notes on Nursing (1860, 1969) with its emphasis on the patient as the passive recipient of care and observation, provides some evidence of how rudimentary such a concept must have been. Only this weak claim for a different orientation to human beings on the part of nursing during its emergent phase can be made.

But the emergence of an active subject within medical discourse was a development seized and elaborated by nursing theorists from the 1950s on, although there were earlier indications. Hawkins (1983, p. 29) credits Frederick and Northam with introducing the concept of recipients as "care agents," around about the same time that medical discourse discovered "the defaulter" (Armstrong, 1982). The elaboration of the active subject can be seen most clearly in the humanist/interactionist theorists, perhaps because of the psychiatric nursing origins of the early members of this group. The active subject is less fully constituted in the deficit-theorists, although partially present, particularly in the more recent work of Orem

(1980) where the subject is constituted as "self-care agent."

The conservation/adaptation theorists have adhered more closely to the man-as-machine model, perhaps because of their adoption of homeostasis and systems theory, with their inbuilt automatonism. Medicine, too, has adopted homeostasis as a way of re-constituting the human being from his parts, but medical homeostasis concentrates on within-body phenomena, while nursing homeostasis tends to move from the skin out, although there is some overlap. But both constitute a passive, reactive, human being.

Using a homeodynamic framework, Rogers (1970) combine something of both these approaches. Man (sic) is in dynamic interaction with his environment, evolving unidirectionally along a space-time continuum, increasing in complexity into an infinite future of increasing complexity, as he moves beyond the earth itself to other planets. But he is creative with, rather than reactive to the environment.

Thus the "human being" part of the metaparadigm seems to reveal little agreement on what human beings are. Since this is a very ancient philosophical problem, nursing can hardly be expected to solve it, but it can perhaps make a choice. The emerging choice seems to be for the active subject concept. Even in the writings of Roy, the active subject has a tendency to emerge, although repeatedly repressed by the framework she has adopted.

The Environment

While medicine has tended to focus on the internal environment within the patient's body, nursing, with restricted access to this region, has tended to concentrate on the external environment, that is, the environment from the skin out both physically and socially. But since this can encompass the whole universe, and there are limits to nursing's interests, it is important to look more specifically at what the various nursing theorists "count" as environment.

In general, the interactionist/humanist group are primariy interested in the social environment at a micro level, commonly the nurse-patient dyad. Even within this dyad, the nurse is usually considered only in relation to the patient's "needs," to the relative neglect of the nurse herself. The more recent theorists in this group have given more space to the nurse, Paterson and Zderad, for example, seeing the relationship as productive of "growth" for both. King theoretically admits the ideological constructs of "family" and "community," but in the detailed working out of her theory concentrates on the nurse-patient dyad.

The conservation/adaptation group has more of a tendency to address within-body phenomena, but the bulk of their theory also concentrates on the nurse-patient dyad, with some lip service to "family" and "community" at times. The four adaptation modes identified by Roy (1980), for example, are physiologic needs, self-concept, role function, and interdependence. She claims that a person is in constant interaction with a changing environment (1980, p. 180), but she does not explicitly specify the environment of

interest. An implicit definition is, however, contained in her list of adaptation problems (Roy, 1980, pp. 185-186). Physiological needs seem to occur at the body surface where events within the body become manifest on the surface of the body. Self-concept problems include the effects of damage to the "physical self," "the personal self," and the "interpersonal self." The examples she gives, however, show no clear differentiation between these concepts. It is similarly hard to distinguish self-concept from role mastery and interdependence by the examples she gives, the interdependence mode being particularly striking for its list of what are normally considered individual human failings. The environment, for Roy, is thus very much concentrated within and around the person.

The deficit theorists similarly concentrate the environment very close to the person. Only Martha Rogers (1970, 1980) with her vision of universal interconnectedness seems to be an exception. She defines the environment as that which lies outside any given human field, but sees each human field as unique (as is each person's environmental field). Although the environment is the universe, her delineation of unique human fields again suggests a concentration around the person.

There is nothing inherently wrong in such a concentration on the micro-environment--nursing patently cannot solve all the riddles of the universe, Martha Rogers notwithstanding. But the use of the broad, undefined term "environment" in the "metaparadigm" conceals the limitation that is implicit in the writings. Acknowledging this limitation allows a more clear conceptualization of the wider world beyond nursing, from which we can start to examine the way they

interrelate. A nursing environment co-extensive with the world in theory while in practice more narrowly focused tends to divert attention from the way nursing interacts with its environment--the wider society in which it is placed. I am thus not arguing that nursing should not examine wider issues--indeed, to the contrary--but that a clearer specification of our prime environment of interest may provide a better conceptual base for seeing how nursing relates to the wider world.

Defining the environment more clearly may help to focus nursing research. Indeed the development of clinical nursing research seems to already accept such a restriction of the term, environment. Perhaps it may encourage also research that links nursing to its society.

Health

Nursing theorists have claimed that nursing is concerned with health rather than disease or illness, basing their claim on Nightingale's equating of the laws of nursing and the laws of health (Nightingale, 1860, 1971, p. 9). But in Nightingale's thought, the principles of good nineteenth century housekeeping mesh with a romantic faith in nature as healer (sanitation plus Wordsworth, perhaps) to produce a concept of health far removed from its emergent meaning today, which nursing theorists have tended to embrace. For Nightingale, health is a far more passive concept than the way it has been constituted 100 years later--as an individualized goal to be actively sought rather than a "natural state" to which the sick are

restored (whether by nature, physique, or good nursing).

Nightingale's concept of health was much closer to the ascendant medical model than today we would like to believe. This conceptual agreement alllowed for the complementarity of doctoring and nursing which is so evident in Nightingale's writings. The laws of health and nursing were to be studied, not to promote "high-level wellness" but to heal the sick and reduce infant mortality (Nightingale, 1860, 1969).

The idea of health as a positive rather than negative state (absence of illness or disease) seems to have been a fairly recent construction in Western society--one which is now being widely marketed as a consumer good (health clubs, running shoes, health food stores, therapies aimed at "expanded consciousness" and "self-actualization," for example). The separation of health conceptually from illness, disease, and disability means that no longer can we rest content that we are healthy, because not sick. Neither are the sick and disabled thereby excused from the pursuit of positive health, in contrast to seeking merely a cure or amelioration of their condition. While this has its positive aspects, it is also highly oppressive in its demands, particularly since the old linkage of illness and health still lingers. Who can claim when sickness strikes that s/he has at all times been obedient to the gospel of perfect health?

Although the concept of health as a personal achievement may be useful to some people on an individual level, it brings with it the likelihood of further alienation from the body as the body becomes

object to be shaped and mastered, in line with technological self-understanding (Benner & Wrubel, 1989). The consequences of this in the area usually called "mental health" have been traced elsewhere (Dunlop, 1989) in making the argument that "mental health" depends on the healing of the mind-body split arising out of Cartesian dualism.

Newman defines health as "the totality of the life-process, which is evolving toward expanded consciousness" (Newman, 1979, p. 58). For her, health encompasses illness and pathology which are seen as part of the totality. Newman's definition of health is clearly developed out of Rogers' work, although Rogers herself hardly mentions health. At its most extreme, this view threatens to obliterate both nursing and medicine as disease is seen as part of the life-process and even as an "integrating factor" (Newman, 1979, p. 58). Individuals have patterns that exist prior to structural or functional change and presumably such patterns are possible sites for intervention, although justification for such intervention may be hard to come by once the health-illness distinction is erased. It is perhaps as well that the old health-illness distinction, at least in practice, continues to co-exist with the idea of health as expanded consciousness.

Another idea of health is evident within the thinking of the humanist/interactionist theorists, perhaps reflecting their psychological background and/or their involvement in helping patients live with chronic illness. Thus, Peplau's nurse promotes personality development, Hall's nurse nurtures the patient toward self-understanding, and Travelbee's nurse helps the patient find meaning in suffering. As early as 1952, Peplau defined health as "the forward

movement of the personality and other ongoing human processes in the direction of creative, constructive, productive, personal and community living" (Peplau, 1952, p. 12). This approach is close to that identified by Benner and Wrubel (1989) as health as a sense of coherence.

Other nursing theorists have been somewhat more conventional in their approach to health. Roy (1980) tends to adopt a health-illness continuum model, along which individuals shift in accord with adaptive and maladaptive mechanisms. This is perhaps typical of the conservation-adaptation view. For Orem (1980), health is structural and functional soundness, biologically, psychologically, interpersonally, and socially, but consistent with her self-care model, individuals evaluate their own states of integrity and wholeness.

Comoroff (1982) explores biomedical individualism in the West in contrast to a small-scale, pre-capitalist society (the Tshidi-Baralong of South Africa). She argues that the biomedical model

> Asserts a cogent, if implicit, world-view, centered upon man as self-determining, biologically contrived individual, who exists in a context of palpable facts and material things.... As new orthodoxy, this strongly reinforces the process of reification, stripping away the social and environmental underpinnings of disease. (Comoroff, 1982, p. 57)

She further argues that even as we have attempted to expand the frame of reference, it has been within the conceptual base of the individual, the opposition between self and socio-cultural system remaining central even "in the vast majority of so-called 'holistic'

health movements in the wider society" (Comoroff, 1982, p. 62).

While nursing, at least theoretically, may have shifted its focus from illness to health, it is clear that it has done so within the concept of the individual. Even where it has explicitly addressed to "the family" or "the community" it has tended to view these as "reified, decontextualized entities" (to use Comoroff's term).

Perhaps the only commonality in the definitions of health is the individuality of the focus. The most worrying thing about the expanded consciousness of high level wellness concept of health is that it confronts the nurse, in an even more extreme way than it does the individual human being, with an infinite task--if we take the goal of nursing to be helping others achieve health. A more practical solution might be to accept a situationally-defined view of health where health is optimal rather than maximal functioning of that person at that time. This might be seen as the product of negotiation between patient, nurse, and doctor within the cultural meanings of the wider society. To leave the matter to the patient's self-definition alone is to rob him/her of the possibility that a more experienced eye may see. But, equally, to exclude his/her reality is to foreclose the possibilities that his/her own self-knowledge may disclose. Such an approach would be reasonably consistent, at least in spirit, with most of the nursing theorists.

Such an approach is still an individual one, but nursing <u>is</u> individually focused. Again, as in the case of the environment, naming it as such assists recognition of its limitations, which are basically the limitations within which nurses work--their mandate from

society as nurses. Clarifying that this is a very individualized definition may help to focus our attention more clearly on how such an individualized definition interacts with the society and culture in which it is formed.

A situational definition of health renders it more researchable, although it probably requires the development of imaginative and novel methods. It is at least more promising than exuberant notions of "high-level wellness."

Nursing

What theorists mean by nursing is good nursing, as Stevens (1978) points out. There are even more views on good nursing than there are on health and it is even more impossible to find commonalities. Obviously, differences in views of the human being, environment, and health augment each other when they come together in the central issue of defining nursing. I do not propose to deal with these at this point, but rather in the context of the study of the NSW documents (see Chapters X-XII). At this point, I intend to come at the question in an alternative way.

As Benner (1984) has demonstrated, good nursing is a highly context-dependent activity. It will obviously differ according to the social setting in which it is practiced, but, more importantly, it will vary from one situation to the next. While there may be commonalities between situations, they are not of the type that can be abstracted from their context in the form of rules which will always apply and thus provide a definition of the activity. This is not a

unique characteristic of nursing but one it shares with other skilled occupations.

Thus the good nurse will often, although not always, act to promote adaptation, sometimes, although not always, act to promote "symphonic interaction between man and his environment," sometimes, although not always, help the patient find meaning in suffering and so on. The reason for this is that sometimes adaptation, symphonic interaction, or meaning in suffering will not be appropriate goals, because of the context.

From the foregoing discussion, it seems that it may be possible to narrow the paradigm a little by frankly acknowledging the individualized focus of nursing as far as human beings and the environment are concerned. This would be a realistic view, yet it would run up against strong ideological blocks and counter-examples--the sort of things that gave rise to the pseudo-universalization and meaninglessness in the first place. If one tries to encompass everything that any good nurse might possibly do on any conceivable occasion, then one simply ends up with confusion.

If the line of an ecological science is to be pursued, we need to focus in more on how nurses <u>generally</u> operate in the world, and the definitions of the individual, environment, and health they <u>generally</u> operate from. We might then be able to even conceive or concede that some of the things a nurse might on occasions do may not have to be nursing necessarily. Every occupation has its central core, its hazy boundary regions, and its idiographic elements which provide an area of freedom in interpeting the role. Additionally, in many, perhaps

all occupations, people do things that are not within the role at all, that come from other roles that people also occupy concurrently with their work roles.

The "metaparadigm" as currently constituted provides little understanding of nursing, nor does it provide any clear guidance for research. It seems to be a dead end. To convert it into anything else would require a sacrifice of breadth for the sake of depth--a sacrifice that nursing so far seems unwilling to make.

There is, however, another strand of nursing theory which does not seem to be fully encompassed by the idea of an ecological science. Strongest in the humanist group, it is the concept of nursing as "helping" or "caring." The clearest early statement is that of Wiedenbach (1964) who saw nursing as a helping art, akin to mothering. More recently, this approach has been explored as a possible basis for a science of nursing by Watson (1979) and Leininger (1978, 1981) in particular. It is to this conceptualization of nursing I now turn.

CHAPTER IV

NURSING AND CARING*

Man's love is of man's life a thing apart
'Tis woman's whole existence
(Byron, "Don Juan")

Today, under the influence of the feminist movement, we may be more inclined to see Byron's poetic statement as representative of the material life conditions of nineteenth century middle-class woman rather than as expressing an eternal truth about female nature. We might also be inclined to tie the denuding of male existence--the separation of "love" from "life"--to the mode of commodity production and its "rational" division of labor which relegated "love" to the place of a leisure-time activity outside the ambit of "life" which was equated with work.

If we look at the so-called leisure of middle-class Victorian women and its dependence on the presence of (a) supporting male(s), it becomes clear that "love" was indeed women's work, that is, it was their means of securing their livelihood. Any direct acknowledgment of this, however, threatened the moral division between prostitution and marriage. Thus, women were seen as embedded in a life of love rather than work, where relationships were based on the "gentler" emotions, of which women became custodians as middle-class norms were

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promulgated as the "right" way of living.

The emergent usage of the word "caring" seems to involve a form of love. Recent nursing literature has picked up the word "caring" and the idea that nursing is a science of caring is gaining popularity (Watson, 1979; Leininger, 1978, p. 80; University of California, San Francisco, 1983). Exploration of "caring" is also taking place outside of nursing (Gilligan, 1982; Meyeroff, 1971; Noddings, 1984, for example). In this paper, I intend therefore to explore the idea of "caring" and pose the question of its compatibility with science.

Caring as an Emergent Construct

I have referred to the emergent sense of caring, because there is little evidence that "caring" in the sense that it is now being used is a longstanding meaning of the word. Bevis offers Rollo May's 1969 definition.

> It is a feeling denoting a relationship of concern, when the other's existence matters to you; a relationship of dedication, taking the ultimate terms, to suffer for, the other.
> (cited in Bevis, 1980, p. 50)

This is a decided elaboration, amounting to a shift in meaning of the term compared to the meanings given by the Oxford English Dictionary (OED), even as amended by its 1966 supplement. Of the four meanings examined, the one that seems to come closest is the third meaning (i.e., "to care for" meaning to take thought for, providing for, look after or take care, of), but this meaning does not have the feeling component which is central to May's definition.

There is a fourth meaning given by the OED which it sees as being

used largely negatively and conditionally. In this construction "not to care" passes from the notion of not to trouble oneself to those of "not to mind, not to regard or pay any deference or attention, to pay no respect, to be indifferent." The emergent meaning of "care" and "caring," as exemplified by May, could thus perhaps be better understood as the negation of the negation in the fourth meaning.

Citing Partridge, Bevis (1980, p. 50) claims a common origin for "care" and "cure," but the OED carefully distinguishes their separate origins, albeit originally common meaning. "Care" comes from the Old English "carian" denoting in the verbal form "to trouble oneself," whereas "cure" comes from the Latin via French (curé in France is still a priest). This is an important distinction, because, with the Norman conquest of England, Anglo-Saxon became the language of the conquered, French the language of the conqueror. As the languages came together, many Anglo-Saxon terms retained their "vulgar" or "lower-order" associations. Thus the conquered Anglo-Saxons looked after pigs or swine (Old English) which became pork (from the French "porc," similarly meaning pig) when slaughtered and placed on the lord's table. The different origins of "care" and "cure" are thus suggestive of an original class difference in the terms--that the higher orders "cured" while the lower orders "cared." While the meanings of the terms have developed in their separate ways, the relationship to power seems to have remained, with "cure" continuing to express a more direct relationship of power and control.

The purpose of this excursion into etymology is to suggest that "caring" as a concept for ordering human emotions is in the process of

being invented or constructed. At the same time, the term brings its complex past with it, including its negative and lower-order associations which may prove hard to shift, because they are so embedded in the background meanings. It seems to be no accident, in others words, that "cure" is associated with a high-status, predominantly male occupation which jealously guards access to the term, while "care" is relegated to women (and, particularly in relation to things, to low status males as well as females).

We might see the emergent construction of caring as a response to problems of "people-work" as it has emerged from the private domain of the home in the forms of health, education, and welfare (Stacey, 1981). Within the private domain care in the old sense had taken place within the context of love--of personalized affection. The vast literature on the effects of depersonalization in health, education, and welfare can be seen as a public acknowledgment of the problems of separating "care" from "love," and the enriched meaning of caring which is emerging can be seen as a way of attempting to solve the problems. Since care of people in the old sense has been the traditional concern of women, the proposed solution carries the implication that the problems are the result of female deficiencies and should therefore be solved by women. This must seem additionally appropriate, since the vast majority of people-workers are women, although they rarely occupy positions of power and control within the health, education, and welfare systems.

The deficiencies of the system are thus to be remedied from below by the relatively powerless. They are to be charged with humanizing

the systems through "caring" in its new sense, while the structures themselves remain above the strife, deficiencies being located in "uncaring" individuals. The stability of the structures, their immunity from criticism, can thus be seen to depend on the development of a particularistic and individualized caring ethic. That this particular package is being bought speaks volumes for the continuing strength of female socialization into both "care" as it used to be and "love" which Byron saw as "woman's whole existence."

This is not to denigrate the emergent concept of caring, which is an attempt to come to terms with real problems. Indeed, I would argue that a central task nursing took upon itself was the translation of "love" into the public domain. But an unexamined adoption of the rhetoric of caring may blind us to its limitations, as I have explained.

With this in mind, let us turn to look more specifically at nursing and its attempts to develop what has most recently been termed "a science of caring." In this discussion, it will become clearer why I speak of an emergent meaning of caring.

Nursing as Caring

Dean and Bolton argue that, in nineteenth century philanthropic thought, care was "the means by which the conditions likely to produce danger [were] constantly monitored and kept under control." The business of the nurse was thus seen as "'caring' for the sick, preventing all conditions detrimental to the health of the individual and family, thereby offering a guarantee of the well-being of the

population" (Dean & Bolton, 1980, p. 82). Nursing was thus the individualized arm of the public health movement, and can be seen as extending care in the old sense into the public domain.

But in the private domain, "care" had been linked with "love" in the pattern of female socialization, particularly in the middle-class home with its heightening of emotional sensibility, and it was probably difficult for females socialized in this way to separate them. In Nightingale's Notes on Nursing (1860, 1971), for example, particularly in the sections on "Noise" and "Variety," Nightingale asks her readers to put themselves imaginatively in the place of the invalid in order to consider the effects of the behaviour of others and themselves upon him. She is thus demanding of those who nurse the sick something of the quality which is now called empathy--the ability to place oneself imaginatively and sensitively in the world of the other. Such a demand requires a measure of caring in the emergent sense, although Nightingale uses the word care itself in the old sense, very much in line with its philanthropic meaning as discussed by Dean and Bolton.

The 1936 nurse cited by Melosh (1982) claims that she always asks herself how the person who loves the patient the most would work out the solution to the problem she was confronting as a nurse. Thus, she continues to link "care" and "love," although the love has become indirect--she acts as if she were the one who greatly loved the patient.

The "as if" is important in marking a transition from the "love" of the private domain to the "caring" (in the emergent sense) of the

public domain. It is also suggestive of the way that nursing retained the linkage of the private domain between "care" and "love"--a linkage is still apparent when nurses talk about their practice. In her recent study, Benner found that nurses "identified with their patients by imagining themselves or their family members in the same predicament, and they reminded themselves of the 'otherness' of the patient when such identification distorted their caring" (Benner, 1984, p. 209). From the context, it is clear that "distortion of caring" refers to the use of power to dominate, coerce, and control--in other words, to act as if one were indeed the patient or close relative. Thus, the "as if" provides both linkage and separation.

It is within this context that the apparently contradictory messages of nursing education make sense. Benner (1984, p. 64) recalls being warned in nursing courses against becoming too involved. I, too, can recall being repeatedly told this on another continent and in a hospital-based programme with little theoretical input. But, at the same time, I can recall numerous occasions when I was asked, "How would <u>you</u> feel if it was <u>your</u> mother, father, sister, brother, etc.?" Thus, in a very atheoretical way, nursing sought to teach me to maintain both separation and linkage in my practice--separation, "you must remember that the other is a stranger" and linkage, "you must think and act as if he were not." Thus, one achieves something like "caring" in its emergent sense as it is applied in the public world--a combination of closeness and distance, which always runs the risk of tipping either way.

Within this context, the tendency to claim caring in its emergent sense as central to nursing is very understandable, even more understandable in view of its earlier and continuing more physical meaning, since care of the sick or disabled human body has long been the province of nursing. The collapsing of these two meanings of care seems to provide the basis for the truth-claim that nursing is caring. In other words, the longstanding involvement of nurses in physical care is being used to claim caring in its emergent sense as in some way unique to nursing, which is quite clearly false. The situation is particularly ironic in the light of the tendency within nursing theory to ignore the body and its associated physical care.

Nursing and Physical Care

In 1964, Wiedenbach introuced her book on nursing as a helping art by declaring,

> People may differ in their concept of nursing, but few would disagree that nursing is nurturing or caring for someone in a motherly fashion. (Wiedenbach, 1964, p. 1)

Thus, the "as if" model that is being used is that of the mother and is one which allows a large place for physical care.

Lydia Hall, in 1966, placed considerable emphasis on the nurse's role in care of the body. It was this physical care, she claimed, that provided the access that allowed the nurse to be an effective teacher and nurturer (Hall, 1966). While physical care was thus subordinated, in a sense, to the goal of promoting psychological growth, Hall unashamedly saw care of the body as central to nursing.

By contrast, Watson, writing in 1979, etherealizes the body by concentrating her attention on the psychosocial correlates of basic physiological needs--"logocentric caring" as my fellow-Australian, Judith Parker puts it (which I have, on occasions, characterized as "a tendency to lose the bedpan"). She introduces her section on food and fluid needs, for example, in this way.

> Although the food and fluid need is categorized as a lower order biophysical need essential for survival, its satisfaction establishes a vital foundation for a person's higher order needs related to personality and social development. (Watson, 1979, p. 113)

While we would be hard put to disagree with this statement, we find it sets the tone for the whole section. After reading the section, one could be pardonned for believing that the only problems with ingestion of food and fluids are psychosocial in origin! Indeed, her whole chapter on biophysical needs is really about their psychosocial correlates, elimination, for example, being largely caught up in a discussion of Freudian theory.

Watson is instructive, for she titles her book Nursing: The Philosophy and Science of Caring, thus implying that nursing is caring. Yet it is obviously a disembodied caring she has in mind, the type that one would be hard put to distinguish from that of other "caring professions." Watson is not a solitary example. Almost anywhere within the vast corpus of writings on nursing, whether theory or research, the same dematerializing tendency can be seen. McConnell and Duffy (1978), for exmaple, in a five-year review of research published in Nursing Research (1970-1975) noted the relative paucity

of studies dealing in the physical aspects of care in any way--only 11 such within the period examined.

In some way the emphasis on the psychosocial aspects of care can be seen as a praiseworthy attempt to redress the perceived imbalance of an excessively physical orientation on the part of nurses. But it can also be seen as of a piece with the progressive devaluing of physical care as it was delegated to the lower orders of the nursing hierarchy.

The irony thus becomes evident. Nursing has justified its access to caring in the emergent sense at least implicitly, and in Hall (1966) explicitly, on the grounds of its old physical care base which it has been attempting to shed. In practice, of course, it cannot be shed as easily as in theory, although delegation to the less-educated is a partial answer. At a pinch, though, and sometimes through choice, nursing remains embroiled in physical care which involves contact with the mess and dirt of bodily life, even while it is aspiring to the "cleaner" caring that deals with people's minds and emotions. But to the extent that it is able to shed physical care, nursing becomes increasingly hard to distinguish from other occupations who make their living and justify their involvement by recourse to caring in its emergent sense.

While an excessive concentration on physical care may have sometimes led to the ideologically denigrated nursing practice of equating patients with the state of their bodies--the appendectomy in bed 10, for example-- care of the physical body remains an important part of nursing practice. Even when delegated to others, it remains

within the registered nurse's purview and control. Reduction of the person to a body may be seen as one of the recurrent temptations of nursing, but there are more positive ways of dealing with temptation than by flight. Earlier, we have seen how nurses imaginatively place themselves in the position of the patient or his close relatives, and this can be seen as a positive way to resist "the temptation of the flesh." At a more theoretical level, a better integration could conceivably be achieved by exploration of the "lived-body" experience, to which Polanyi (1958) and Dreyfus (1979), among others, have directed our attention.

In her excellent account of motherhood as discipline, Ruddick (1984) discusses the temptations of motherhood in the light of its goals. This seems a useful way of looking at the two problems of that specific form of caring we call nursing that have so far been identified. In caring for sick people, many aspects of whose being-in-the-world become problematic rather than taken for granted, there is a temptation to concentrate either on the troubled body or the troubled psyche in order to simplify nursing work, yet what the nursing community agrees is good nursing is neither purely physical nor purely psychosocial. The nurse must thus find her way between the twin temptations of physicality and disembodiment. Nursing theory in the United States seems to have yielded more to the latter temptation than the former, perhaps because it is a "cleaner" form of caring. But yielding to the temptation of disembodiment may also be seen as a result of the association of physicality with medicine, and nursing's desire to cut itself off cleanly from this world in order to support

its claim that it is an independent profession.

The second temptation was dealt with earlier--in fact, the twin temptations of overinvolvement and excessive distancing. Both represent failure in terms of the nursing community's consensus of what good nursing is, and are guarded against by messages or maxims which, if decontextualized, appear contradictory.

In speaking of the consensus of the nursing community, I do not mean to imply that nurses are everywhere agreed in some transhistorical and transcultural way. I am merely indicating the widespread agreement that exists among nurses of a particular time and place as to what constitutes good nursing. Following Heidegger (1962), I believe that it is not possible to ever fully spell out the bases of such judgments, for they are part of the deep background of the nursing world. They are, moreover, contextual judgments rather than ones made on the basis of some explicit, decontextualized nursing theory. Indeed, Benner's (1984) work rests heavily on the assumption that good nursing practice is readily apparent if one provides the event and its context, and this assumption seems to be a sound one.

While it seems possible to claim that nursing is a form of caring, it seems much less reasonable to claim it as the form of caring (as in The Science of Caring). Such a claim does scant justice to other people-workers who are endeavouring to overcome the problems caused by the movement of people-work into the public domain through caring in its emergent sense. It can reasonably be claimed, however, that there is a particular combination of caring in its old sense and caring in its emergent sense that is recognizable as good nursing,

although (as I have indicated) I am skeptical about the possibility of ever spelling this out in detail, as universalistic nursing theories have attempted to do.

Can There Be a Science of Caring?

There does seem to be a basic contradiction between caring in its emergent sense and science as it is usually understood. To clear the ground a little, let me first suggest that a science or sciences for caring involve no problems greater than those of science generally, for one is simply applying the findings of science to achieve the ends determined by caring. Thus nurses, for example, can research areas of knowledge that are likely to be useful to them in caring, following patterns that have been laid down in public health, epidemiology, physiology, biology, psychology, and social psychology, to mention those diciplines which seem most central to their focus. Nursing-caring may determine the questions, but conceptualization and methodologies are borrowed from the established disciplines.

Some problems arise when attempts are made to combine the findings from different fields in other than a mechanical way, since each field has its own focus of interest and own conceptual tools. Thus, there has been considerable interest in building what is seen as a specifically nursing approach which treats human beings "holistically." But even if such a science proved possible, say à la Martha Rogers (1970), it would still be in an important sense science for caring, in this case, a nursing science for nursing-caring. In other words, science would provide tools for the enterprise, without

encompassing the enterprise as such.

This is not to denigrate such approaches, provided other sources of knowledge useful in caring are not excluded. Well-informed caring, on the face of it, seems preferable to poorly-informed caring and there is enormous scope for improving the quality of information available to nursing. But a science of caring has different implications.

Within the traditional view of science, a science of caring implies that caring can be operationalized in some way as a set of behaviours which can be observed, counted, or measured. This is the approach adopted by Watson (1979) in her listing of 10 primary carative factors, which are then individually examined. It is also the approach of Leininger (1981) in her development of a taxonomy of caring constructs (28 to date). These can be characterized as attempts to describe caring in terms of a set of context-free variables. The difficulties of this approach can be seen by simply examining the carative factors listed by Watson (1979, pp. 9-10) and the taxonomy of Leininger (1981, p. 13), for these are no more context-free than the caring they seek to operationalize. It is by no means obvious, for example, that comfort, compassion and concern (to take the first three on Leininger's list) are any easier to establish than caring itself. While it is probably true that what counts as comfort, compassion or concern also counts as caring, we still have the problem of delineating what counts as comfort, compassion and concern, which is, I would argue, highly dependent on context.

Dreyfus (1984) argues that a fundamental problem arises in the

human sciences because it is not possible to describe human capacities in terms of context-free features, abstracted from everyday contexts, as the natural sciences have done. While, in principle, it is possible to develop a science of human capacities using features other than those used in everyday practice, "we have no precedent for such a theory, no reason to believe the abstract features it would require exist, and no way to find them if they did" (Dreyfus, 1984, p. 15). The truth of the findings of human sciences is thus always vulnerable to changes in the practices from which the supposedly context-free features are drawn.

Although Leininger (1978) is hopeful of finding transhistorical and transcultural aspects of caring, it seems likely that such a project will run into the same difficulties as structuralist accounts of, say, language (Chomsky) and culture (Levi-Strauss). What counts as caring is highly context dependent, as Leininger herself points out. I have suggested that, even within Western society, the term "caring" has developed its meaning in a historical context. This does not prevent the claim being made that something to which the term "caring" is now applied exists as a transhistorical and transcultural reality, and this seems to be what Leininger is hoping. But, as Dreyfus argues, it is not at all clear how such an entity, if it existed, could be designated or described.

Philosophically, Noddings (1984) attempts such an undertaking, by grounding caring in the universal memory of being cared for. In order to survive, the human infant requires care, and to become a human being it needs human care. She thus traces one root of human caring

to "the longing to maintain, recapture or enhance our most caring and tender moments" (Noddings, 1984, p. 104) although if, why, and how we separate these from the primitive world of pain of the human infant is left unexamined. The other root of caring she sees as lying in "the natural sympathy human beings feel for each other" that enables them to feel "the pain and joy of others" (Noddings, 1984, p. 104). She thus seems to be suggesting both a nature and nurture source for caring. This could perhaps be seen as analogous to language, where the capacity to develop speech can be seen as innate (in a certain arrangement of mouth, nose, vocal chords, and brain), but the particular forms that speech takes is learned socially. The apparatus that provides the capacity for caring, however, is much less clear-cut (or so it seems).

Bevis draws attention to the fact that Heidegger speaks of care as the source of the will (Bevis, 1980, p. 50) and, superficially, this may seem to provide some support for Noddings' claim that caring is, in some way, innate. But Heidegger is using care (German--sorge) in a more general sense to speak of the deep involvement in the world which he sees as necessary to any human activity. In some sense, sorge is a human-centered version of Dante's conclusion of The Divine Comedy.

> My will and my desire were turned by love
> The love that moves the sun and other stars.
> (Dorothy Sayers' translation)

Sorge, as the source of the will, is that which connects us to the world. It is neither positive nor negative in the usual moral sense, but simply is. This is why Being-in-the-World (Dasein) in an

important sense is care (Sorge) (Dreyfus, 1983). But we can obviously care about such things as the purity of the Aryan race, as Hitler did, and such caring will structure the world in particular ways.

Heidegger does, however, distinguish two kinds of care--care for things (concern) and care for other Daseins (solicitude). According to Dreyfus, Heidegger sees solicitude as a type of care which reveals certain other beings, not as ready-to-hand or present-to-hand (i.e., like objects) but as there with us in the world (Dreyfus, 1983). This suggests both a specificity of focus (certain other beings) and a type of caring that recognizes the "beingness" of the other.

But Heidegger's "solicitude" offers little comfort to those who would seek to develop a science of caring, at least in the traditional sense of science (and probably in any conceivable sense). As a part of the source of all-there-is for human beings, to examine it using tools like science that are part of its product is to involve oneself in absurdity. To operationalize it is to operationalize all-there-is, and, even if this were possible, sorge would still escape us because it provides the grounds which make operationalization possible. Thus there is something incongruous between the use Bevis (1981, p. 50) makes of Heidegger and her development of a four-stage hierarchical model of caring (attachment, assiduity, intimacy, and confirmation--each stage being attained by successfully completing the tasks necessary to each stage).

But it is possible, still following Heidegger, to see caring as a certain mode that Being-in-the-World can adopt, as a particular expression of sorge. As such, it can be retrieved from the background

and subjected to examination, which is basically what those who examine caring as moral activity do.

The question that then arises is how best it can be examined. In deciding this question, we are in fact deciding the form that caring will take. But our conceptualization of caring will also guide our decision as to how it can best be examined. If we conceptualize caring as a finite set of caring behaviours, then caring can be examined in the traditional scientific way. But, equally, if we operationalize caring in terms of context-free variables (despite the difficulties examined by Dreyfus), we are likely to end up with something different to what we now recognize as caring. (The trick has been performed before, perhaps most notably in the case of intelligence.)

Although Noddings claims caring as a universal basis of morality, she sees a basic incompatibility between caring and universal rules.

> Caring involves stepping out of one's own personal frame of reference into the other's. When we care, we consider the other's point of view, his objective needs and what he expects of us. Our attention, our mental engrossment is on the cared-for, not ourselves .... To care is to act not by fixed rule but by affection and regard.... Variation is to be expected if the one claiming to care really cares.... Rule-bound responses in the name of caring lead us to suspect that the claimant wants most to be credited with caring. (Noddings, 1984, p. 24)

While it can be argued that Noddings is accepting and using a particular historico-cultural concept of caring, it is recognizably what I have previously termed the emergent concept of caring in our own historico-cultural context. (One might note, for example, its

highly individualized nature as a mark of its roots in a highly individuated society. It is possible that it is in just such a society that caring becomes problematical enough to be noticed or even named.) It is also the concept that Bevis (1981) is picking up in the context of nursing, although unlike Noddings, Bevis seems to believe that it can be cost-free to the carer. Benner is more realistic when she says,

> The demands of nursing are large ones. The pains, risks and dangers encountered are sometimes great and cannot be experienced without personal cost. (Benner, 1984, p. 208)

But, for Noddings, to count the cost is to place oneself in the unethical position of not caring. As T. S. Eliot has Beckett say, as he is facing martyrdom,

> The last temptation is the greatest treason
> To do the right deed--for the wrong reason.
> (Murder in the Cathedral)

Caring is thus seen not to reside in a set of practices, but in a thinking-feeling (thoughtful in its fullest sense) mode of being which gives rise to activity (including the activity of refraining from activity).

How can such an entity be examined? We have seen how it cannot be subjected to traditional scientific inquiry without distorting it past recognition. There are two problems with developing a science of caring along traditional scientific lines. The first relates to its historical and cultural specificity, and this problem it shares with other concepts investigated by the human sciences. The second lies in its negation of universality--if it could be captured by rules, it

would not be caring (and this seems intuitively reasonable). In this, too, it is not unique. If, for example, we consider language, we can see that our culture provides us with a vocabulary of words and patterns for their use, but to simply use set words and follow set patterns is, in an important sense, not to really speak the language. Similarly, our society can be seen as providing us with examples of caring, but to simply copy these is to lay oneself open to the charge that one does not <u>really</u> care.

Dreyfus (1984) cites the case of Socrates asking the prophet Euthyphro for a definition of piety. In reply, Euthyphro appeals to examples and his own special intuition, a reply that Socrates angrily rejects, for he is looking for a universally applicable definition. (He wants the concept operationalized.) In arguing for the use of paradigm cases (examples) in the human sciences rather than universalizing theory, Dreyfus concludes,

> After 2000 years it seems clear we must give credit to Socrates and Plato for the vision of theory which has flourished in the natural sciences, but in the human sciences it might turn out that Euthyphro, who kept trying to give Socrates paradigm cases rather than abstract rules, was a true prophet after all. (Dreyfus, 1984, p. 17)

It seems unreasonable to dismiss the knowledge obtainable by the human sciences in following the natural science model out of hand, although it seems entirely reasonable to dismiss its worst excesses. It does need to be recognized as knowledge which is historically and culturally specific, for the reasons argued by Dreyfus. Moreover, even within the same historico-cultural time-frame, it is limited to statistical prediction and could only be otherwise within a completely

homogeneous culture of genetically identical individuals.

But the problem of explicating caring seems to have much in common with explicating piety. This suggests that if nursing really wants to have a science of caring (as distinct from science for caring) then it may have to take a hermeneutical form, as Dreyfus (1984) suggests. This is the approach that Benner (1984) adopts to uncover the knowledge embedded in clinical nursing practice. As she does this, she is also uncovering the nursing-caring with which it is deeply intertwined. This is extremely useful in elucidating nursing-caring and demonstrating the sort of possibilities for caring that nursing presents. But it does not provide us with any universal truths about caring in general or nursing-caring in particular-indeed, it does not make any such pretension. Even less does it provide us with predictability, and even less does it intend to do so. What it does do is say "these are the sort of skilled things that nurses do, these are the sort of ways they work out their caring in practice." As in nursing theory, the focus is on good nursing rather than on the bad or indifferent which, one can be sure, also abounds in the real world.

Also missing is the point of view of the cared-for (to use Noddings' term). We might well ask what patients experience as caring, and this is a potentially fruitful line of investigation that could be pursued. The line pursued so far tends to assume a congruence between the nurses' and patients' views of caring which may not be warranted. But this is by way of showing that there are other possibilities within the approach which Benner has opened up.

Conclusion

If a science of caring is possible and we wish to maintain the emergent meaning of caring, then it must take a form that in many ways does violence to our traditional ideas of science (which are in considerable upheaval anyway). A science which neither explains nor predicts in the usual sense is profoundly unsettling. Yet, looked at in another way, it is also profoundly comforting.

For if caring were the sort of entity that could be analyzed into its component parts and spelt out in universal rules, it would mean that, at least in principle, it could be computerized and nurses would become obsolete. This seems to be true also of caring in the older sense. This is not the place to pursue the argument, but care of the physical body seems to require that the carer have a physical body, at the most mundane and emotionally detached level of care imaginable.

The possibility also opens up of developing science in ways that will better encompass the traditional concerns of women. Fox Keller (1984) argues, following Simmel, that science, in its actual historical configuration, has been masculine throughout--in ways that painting and writing (also performed largely by men) have never been. The sharp separation of subject and object which underlies our ideas of science she sees as having its psychic origin in the radical separation of the male-child from the mother (as in Chodorow's [1978] account). The female-child separates less radically because she is unable to define herself as so radically "other." As Fox Keller argues,

> The recognition of the independent reality of both self and other is a necessary pre-condition both for science and love. It may not, however, be sufficient--for either. Certainly the capacity for love, for empathy, for artistic creativity requires more than a simple dichotomy of subject and object. Autonomy too sharply defined, reality too rigidly defined, cannot encompass the emotional and creative experiences which give life its fullest and richest depth. (Fox Keller, 1984, p. 193).

A science of caring thus challenges the male hegemony of science in a way that science for caring does not.

This is not to suggest that the hermeneutic approach is a feminine one--after all, it was developed by males, as was the concept of equality on which women based their arguments for equal rights. But it <u>is</u> to suggest the need to explore all possibilities our intellectual tradition affords us to articulate women's traditional concerns in language that the dominant male culture can understand. In such a struggle, which has a strong intellectual component, nursing and feminism can be fruitfully allied, for recognition of nursing skills, knowledge, and values is part of the broader struggle for recognition of women as thinking (as well as feeling) beings who operate intelligently in the world.

I end on a note of caution, which arises out of the introduction. There is a need to develop concurrently with consideration of caring itself a critical evaluation of the structures in which people are expected to care. A more powerful and public statement of caring can be of assistance but is not in itself sufficient. There is little reason to doubt that caring is profoundly shaped by the social structures of the institutions of care. Harding (1980), for example,

explores the way altruism is "cooled out" and subverted in nursing.

In this enterprise, too, nursing can be fruitfully allied with feminism, and in particular those within it who are concerned that the qualities that have been nurtured in the traditional world of women should not be lost. This amounts to more than the demand that men should share the caring, although as Chodorow (1978) points out, if this were practiced on a wide-scale, it could do much to change the psychological structure of both males and females. It is a vision of a different sort of society, perfused by caring, that would be more flexible and attuned to the meeting of human needs. Although such a society might reduce the need for nursing, it is a vision that feminism and nursing can share.

CHAPTER V

NURSING KNOWLEDGE AND THE CURRICULUM

As I have argued, modern nursing displays considerable continuity between the work that women have traditionally done as paid and unpaid health care workers. It seems clear, following the arguments of Ehrenreich and English (1971, 1978) that a transformation of women's health-care work accompanied the growth of modern scientific medicine which involved the division of cure from care. As the human body was increasingly constituted as a passive mechanism, the ability to intervene in the functioning of the mechanism became the prerogative of doctors--a prerogative enshrined in law. The empirical remedies which had been used in care of the sick became either scientized where appropriate or dismissed as "old wives tales", although many of the latter still retain something of their hold in the popular culture, and, in recent years, have even undergone a resurgence. (By the same token, the scientization of much accepted medical practice is still far from complete.)

Although Stacey (1981) traces the partial movement of women's service work out of the private domain of the home into the public world of the marketplace, Graham (1985), in her treatment of women as hidden carers, demonstrates the extent to which the formal health care system still relies on an informal one provided largely by the unpaid labor of women. Thus nursing, insofar as it accomplishes in the public domain work that was previously and, to a large extent, still is provided unpaid in the private domain, suffers from the

invisibility of everydayness. It seems to be largely this sort of work that nursing theory has attempted to scientize because it is the part of the nursing role most separate from the role of the doctor. The individualized, holistic approach of human caring, however, sits uncomfortably with the universalizing scientific tradition. It may well be, as some feminists argue, that we need a different ontology and epistemology to approach and develop some sorts of knowledge that have been traditionally embedded in the female world (Fox Keller, 1984, 1985; Whitbeck, 1984).

At the same time, what seems to distinguish nursing as an occupation from women's unpaid caring in the home is precisely the understanding of and familiarity with the knowledge and technological skills of modern medicine. (This distinction is not absolute since a certain level of knowledge of medicine is now part of the popular culture and some elaboration of women's traditional caring has also probably occurred.) Nursing theory tends to assume such knowledge, since it does not directly address it. One cannot, for example, meet the patients' needs in ignorance of the medical diagnosis (e.g., if preoperative patients are hungry, one does not feed them!). Nursing diagnosis alone can be shown to be inadequate for quality, or even safe, nursing care. (The same argument could be made for medical diagnosis, of course, but is seldom recognized by the dominant medical culture.)

Nursing knowledge can therefore be seen as traditional female caring, situated within the context of modern medicine--a context which has become increasingly implicit rather than explicit as nursing

has endeavoured to professionalize by distinguishing itself from medicine. Yet, even if implicit, the medical context remains a coercive one which constrains the development of nursing knowledge because of the privileged position occupied by medicine in shaping the world. What Foucault (1973) calls "the clinical gaze" sets up micro-practices of control (or "biopower") which colonizes human self-understanding so that individuals understand themselves increasingly in terms of the biomedical approach. "The clinical gaze" creates the object body which can be handed over to experts for treatment. Increasingly, this view of the body blocks out or overtakes other self-understandings, particularly those arising from lived experience. Lived experience is thus translated into "scientific" terms as objective correlates ("signs") are sought for human illness experience ("symptoms"). The finding of objective correlates equates with disease and the failure to find objective correlates with its absence. (Sullivan, 1986, traces how this approach developed as a way of approximating autopsy findings.)

If medicine is regarded in this way as "a colonizing culture," the close association of nursing with it leads to a tendency for nursing also to be colonized by it. This can be most clearly seen in the nursing diagnosis approach to formalization of nursing knowledge (Carpenito, 1987), where an attempt is made to build a parallel system to the one present in medicine, but focused around nursing concerns. Although sometimes misunderstood and misapplied, Carpenito makes it clear that the nursing diagnosis is not a substitute for (or a translation of) the medical diagnosis. Thus, she sees the two systems

as co-existing, however difficult this may be in practice. Since nursing diagnosis is modeled on the dominant system, the likelihood is increased of its system being overtaken by the dominant one. The ambition is now to establish a set of standardized treatments according to nursing diagnosis, thus reinforcing the objectified approach--"the clinical gaze" is to become the prerogative of nurses in their own right, not just as "eyes, ears, hands" of the doctors in their absence. To the extent this move were successful, it would extend the ambit of "biopower."

Yet the nursing diagnosis approach shows the same strains as previous attempts to formalize nursing knowledge, a similar attempt, for example, to encompass everything that caring might involve. In the attempt to translate a very wide range of context-dependent activities into context-free terms, diagnoses proliferate and yet fail to capture the situated activity. The popular formula of meeting human needs, for example, on which nursing diagnosis appears to be based, rapidly runs up against the limits of formalization because "needs" are not a delimited category, but are very much formed in a matrix of human temporality, meaning, and interpretation, as I will later argue (Chapter XI). The objectified approach imposes a particular set of needs on the patients/ clients, which, to the extent that they fail to mesh with their own priorities, fail to meet their needs.

Thus nursing, through its insistence on individualized patient care (which is its recognition of its continuing caring mandate) finds itself going around in the same circles in its attempts at

formalization. Yet, even in these attempts at formalization, one can also see an ongoing resistance to "the colonizing culture," perhaps the more remarkable given the proximity of the two "cultures," one with its origin in the Cartesian world view and the other arising in the unformalized traditionally female world of care and nurturance which has proved very resistant to formalization along Cartesian lines.

Nevertheless, the proximity of the two "cultures" and the dominance of medicine require the development of a "bilingualism" on the part of the nurse--the fate of a subordinate culture. Of necessity, nurses require a reasonable grasp of medicine which includes not only the biosciences, but the set of practices, procedures, ways of going about the business, which vary in their degree of scientific warrant and are subject to social as well as scientific change (e.g., the pubic shaving of parturient women).

The scientific content of modern medicine comes out of the applied biosciences. As such it is a body of knowledge neither built up exclusively by doctors nor practiced exclusively by them. It is a mark of the political dominance of a particular group of health care professionals that medicine has been equated with doctoring. The powerful discourse which has so colonized our self-understanding as human beings has thus been appropriated by one group as their special knowledge, thus placing us as human beings under their control to the degree we accept that self-understanding.

Since one would be hard put to deny that modern medicine has delivered up certain methods of cure and control that are important in

the achievement of human well-being, distinguishing between the body of knowledge and its current political control can be liberating for both nurse and patient/client. There appears to be some recognition of this in the assumption by nurses of an interpretative role, made possible because of the degree of nursing access to medicine (which is usually greater than that of the patient/client). The extension of this to a patient-advocate role, which could be seen as interpretation on behalf of the patient/client, demands more. It requires an ability to grasp imaginatively the world of the other, expressing the reality of the other in terms that the dominant "culture" can understand (which goes beyond simple translation).

Although individual doctors may endeavour to substitute "power with" in place of "power over," the overall thrust of the discipline works against such substitution. Similarly, to the extent that the nursing diagnosis approach is successful in developing a biopower discourse, it will in turn need its interpreters and patient-advocates--it will need its "nurses."

Even in the nursing diagnosis approach, however, as Carpenito (1987) acknowledges, nurses continue to require a knowledge of medicine which can be legitimately seen today as part of nursing knowledge. In the context of the design of nursing curricula the question therefore arises as to how the student is to gain a reasonable grasp of medical knowledge if curricula are designed to center around nursing defined as distinct from medicine. Some of this knowledge can be dealt with as pure and applied biophysical sciences, supportive to the nursing major. But this remains problematical,

because there is, as I have suggested, more to medicine than just the application of biophysical sciences. Nurses need also to be familiar with the way medicine goes about its business.

In addition, even if the nursing diagnosis approach is adopted, it remains difficult to challenge a medical diagnosis with a nursing one. The nurse is on stronger ground challenging a medical diagnosis with another medical diagnosis, or one couched in medical terms (one that the dominant medical culture can understand). Hence, there is a need for nurses to be "bilingual" if they are not to become absorbed within the dominant culture.

The spelling out and elaboration of women's traditional caring role confronts other problems that exist around the invisibility of women's work, particularly the lack of public recognition of the skills it embodies. Further, the association of care with feeling (seen as unreliable and misleading [Hochschild, 1983]) tends to also conceal from the public world its skillful nature. Ruddick (1983) addresses this problem by commencing an explication of the discipline of mothering. The lack of appreciation of the very long 'apprenticeship' that most women have thrust upon them in learning caring skills makes for explanation in terms of 'female intuition'--something women are apparently born with, that does not require examination. (However, it is noticeable that intelligence, which a number of schools of thought believe is also basically innate, has been subjected to endless examination. Perhaps the most determining factor is the location of caring in the world of the "other"--against which men define themselves [Fox Keller, 1985]).

Much of nursing, therefore--the part most recognizably different from medicine--remains very closely linked to "natural" female activity, embedded in the everyday practices and taken-for-granted world of female care of the young, the sick, the disabled, and the aging. (Even traditional female care of the able-bodied adult male has its counterpart in "nursing the doctor"--a practice that nursing, like women more generally, is attempting to abandon.) While care of human beings involves certain physical components which may be amenable to a traditional scientific approach, its strong affective component resists translation into objective scientific discourse. Caring involves both activities on behalf of the cared-for and a particular stance of care, concern, and commitment to the cared-for.

While it may be, as Whitbeck (1984) argues, that we need a new ontology--one based on the web of self and others rather than the dichotomy of self and other, a more pragmatic approach may be to reinterpret and develop paths to knowing already present in the culture (a less daunting task than a whole new ontology).

As I have suggested, there are aspects of nursing care--particularly its physical aspects--that are amenable to a mainstream scientific approach, although there are dangers in such separation. But these are, as yet, poorly researched (McConnell & Duffey, 1978). Nursing theory, as such, has tended to focus on nurse-patient interaction rather than physical nursing care (with the partial exception of the needs and adaptation theorists). It also seems that once one gets beyond some very basic comfort measures, one reaches again the intersection of medicine and nursing which is problematical

for nursing's quest for its own discrete body of knowledge. Even very basic physical comfort measures often require organization around the medical diagnosis or in interaction with it.

This would not be so bothersome if we did not continue to equate medicine with doctoring. An alternative conceptualization of medicine could be that of a body of knowledge on which all health professionals draw for their practice--and this might be more accurate. Even more accurate would be seeing it as a body of public knowledge to which we all have varying access, whether health professional or lay. This involves, as I have argued, the conceptual separation of the body of knowledge from one particular way of using it. (This does not, of course, obliterate questions surrounding the gate-keeping function of the doctors through their legislated control of prescription drugs and surgery.)

This seems like stating the obvious, and yet no nursing curriculum would be acceptable that self-consciously and openly sets out to teach medicine as such, whether in the U.S.A. or Australia. At the same time, much of the justification for the move into the colleges and universities lies in the sheer complexity of modern medicine as it is now practiced in hospitals. An ignorant neophyte, unless scrupulously supervised, can be a very real danger to the safety and well-being of patients. (There is, of course, also the argument that hospitals provide an inadequate experience of the range of health care problems, but this has long been true.)

So it seems that under some rubric or other, medicine must be taught. While the scientific base of medicine can be taught from the

disciplines themselves (as is usually done in medical curricula), the practice of medicine is more than a mere application of its scientific base. It is hard to see how this knowledge is to be managed if one adopts a nursing theory as the base for teaching nursing practice (as is often advised), because of the tendency of such theories to put to one side medical knowledge. Thus, in New South Wales (NSW), it is understandable that no colleges have adopted a thorough going nursing theory approach to the development of their curricula, although a number have, in their own words, "based [it] rather loosely on Orem."

This is not to argue that doctoring and nursing operate on identical terrains. There is a reasonable argument that nursing is more oriented to illness (the ways in which human functioning is disturbed, often by recognizable disease processes, but not always), while doctoring is more concerned with disease processes themselves. Thus, while doctors are more inclined to see psychosocial factors as "nuisance" variables interfering with the process of diagnosis and treatment, nurses are more likely to see them as sites for intervention in the interests of relieving illness and promoting health. A clear illustration of this is the way in which doctors, during the 1930s, constructed the active subject as "the defaulter" while nurses also began to construct the active subject as "self-care agent." This distinction, between addressing disease and addressing illness, is far from absolute, and, in its practice and even its research, nursing has continued to be influenced by the dominant medical model, as nursing research on "patient compliance" demonstrate. It would also be unfair to see all doctors as totally

uninterested in the effects of disease and disability on living (there is, after all, a specialty of rehabilitative medicine).

But where disease is present, it would be incompetent and often dangerous for the nurse to treat the illness in ignorance of the disease. (It can similarly be argued that many of the disasters of modern medicine lie in treating the disease in ignorance of the illness, in ignorance, for example, of the effect that treatment will have on ability to function in the world.)

A further point needs to be made about the care that nurses provide which relates especially to physical care. Physical nursing care is something of an embarrassment--jokes about nurses and bedpans reveal the dis-ease of the general public who find very threatening the thought that they might lose control of the private body so carefully concealed behind the sanitized, deodorized (and usually clad) public body which is normally presented to the world through one's own efforts. The embarrassment of the conscious patient who can no longer make such efforts on his/her own behalf is very much part of the experience of every nurse. Skilled nursing practice involves "making the unacceptable acceptable," as Benner (1984) argues. (Doctoring is less affected, because the patient can usually present the sanitized, deodorized (and strategically draped, if unclad) body to the doctor, either through his/her own efforts or those of the nurse.) This area of nursing function is rarely mentioned in the nursing literature, being indeed more publicly visible on the shelves of comic get-well cards. If not taught otherwise, it seems that nurses will deal with this sort of body maintenance by extrapolating

from their own personal experience which may vary in appropriateness, given differences in age, sex, culture, and social class, to name a few obvious variables.

But the literature and research are not readily available for the teaching of this sort of knowledgeable skill. Perhaps we need some patient's-eye views in this area that encompass poor as well as good nursing practice, so that we have a better grasp of the situation. As it is, to the extent that it is taught, nurse teachers will tend to do so by drawing on their own experience in nursing. This may, however, be limited because of the tendency to delegate the teaching of these "basic nursing care" areas to the least experienced staff--a mark of the general under-recognition of their importance and of the skills and knowledge embedded in them. Nursing theory and/or research provide little guidance in this relatively unexplored area. Nursing itself appears not to be immune to the embarrassment of the private body, to judge from the absence of the private body in its public discourse.

A nursing curriculum document is part of the public discourse of nursing. It presents a particular view of nursing to the world. The acceptable public face is that of an independent skilled profession with its own body of knowledge. What is covered over in such an account are the sort of issues discussed above, viz

(a) the continuity between paid and unpaid nursing work.

(b) the use of medical knowledge (including familiarity with medical practice).

(c) the embarrassing care of the private body.

In addition, to the extent that a curriculum attempts to adopt an illness rather than disease orientation, it is faced with a literature that overwhelmingly adopts the disease approach.

The development of a curriculum document could thus be seen as an attempt to match situated nursing practice with the professionalizing ideology of nursing. To ignore situated practice would be to inadequately prepare the neophyte, yet to ignore the currents of professional ideology would risk accusations of being locked into the past--and with some justification, for it is clear that the professionalizing ideology has its place in the re-shaping of nursing practice and in the gaining of better public recognition of its understanding and skills.

Viewed along these lines, curriculum documents can make visible the tensions that continue to complicate nursing's developing as a discipline.

CHAPTER VI

THE AUSTRALIAN BACKGROUND

The development of the curriculum documents which are the subject of this study came about as the result of a landmark decision by the NSW government in November 1983. This decision involved the total and minimally staged transfer of basic nursing preparation out of the hospital-based schools of nursing into the higher education system (Universities and Colleges of Advanced Education) as 3-year student-status diploma programs.

Political Background

Like the United States of America and Canada, Australia has a federal system of government where the constitution limits by naming the areas in which the federal government may legislate, with the residual areas being left to the states. Although education was legislatively a state responsibility, since World War II the funding of higher education had increasingly been assumed by the federal government, being taken up entirely in 1972 by the incoming Australian Labour Party (ALP) Government. The NSW government was thus exercising its latent prerogative by undertaking the funding of the new programs in 14 public institutions and one private one.

They had, however, good reason to hope that the federal government would eventually assume this responsibility, since the recently elected federal ALP government (elected March 1983) had given undertakings to the nursing profession to make such a move while they

were in opposition. Indeed, the move of nursing into higher education institutions had become official ALP policy. But the federal bureaucracy was still advising a very gradualist approach, more in line with the policies of the previous Liberal-National Party coalition government, using the 1978 Report on Nursing Education and Training (the Sax report, after the chair of the committee, Dr. Sidney Sax) as argument. However, the gradualist timetable suggested in this report was well behind schedule.

The NSW move thus put pressure on their federal colleagues, who set up an interdepartmental committee between the departments of education and health which made recommendations in favour of the move, justifying their recommendations on the "legitimate aspirations of the nursing profession" and equity for women. Thus, the federal government was able to announce on August 24, 1984, its acceptance of the advice of the interdepartmental committee. The transfer of basic nursing preparation was to be completed across Australia by 1993, with the financial aspects of the transfer to be negotiated between state and federal governments.

The following month, the then federal Minister for Education, Senator Susan Ryan, clarified that students in the NSW funded programs would be eligible for allowances under the Tertiary Education Assistance Scheme (now Austudy)--a nonrepayable but means-tested student living allowance. At that stage, there were no tuition fees for higher education, although, in 1989, a graduate tax has been introduced which can be paid in advance (i.e, rather than pay fees during their time in higher education institutions, a surcharge on tax

up to a set amount is levied after workforce entry).

For the nursing profession in Australia, who had argued with governments for at least 20 years, the log-jam was finally giving way. They had not got all they wanted--the fight for a degree as initial entry to practice still goes on--but they were finally being freed of the educational constraints of the hospital-based system, with its large component of workforce experience and its very inadequate funding. They were being freed of a system where the education of students had come a very poor second to the staffing needs of the hospitals. Of course, they then had to learn the new set of constraints of the system into which they were moving.

Basic nursing preparation is thus moving into a still largely free (publicly financed) higher education system where means-tested assistance with living expenses is available to individual students. Even so, for nursing students, considerable sacrifice is required in comparison with the hospital-based system where students were salaried members of the hospital workforce throughout their training. Nursing students are thus considerably poorer.

Nursing education is also moving into a highly centralized system. While each state has some control over the accrediting of courses and disbursement of federal monies, the ultimate financial power resides with the federal government in Canberra. It is currently using this power over the purse-strings to force institutional amalgamations which are resulting in the demise of the Advanced Education sector as colleges are incorporated into fewer, larger Universities. The scope of these larger Universities will

resemble more closely those of North America, rather than the more conservative scope of British universities (although these, too, are changing).

In NSW, having initially moved into the more hospitable, vocationally-oriented setting of the Colleges of Advanced Education, nursing education now has to find its feet within the University setting where conservative ideas of what constitutes an appropriate area for university study still predominate. It may require the retirement of a generation of university academics for any substantial change in these inherently "Oxbridge" orientations.

Although the new universities are intended to encompass the full range of teaching from associate diploma through to doctoral level, there is some resistance to the acceptance of courses below baccalaureate level, i.e., the associate diploma and the undergraduate diploma (postgraduate diplomas--sub-Masters level--have always been part of the universities). To date, the federal government, through its financial control, has prevented the introduction of a pre-registration degree, although post-registration conversion of diploma to degree courses do exist. While this situation persists, nursing is likely to be disadvantaged in the enlarged universities currently coming into being.

According to the Australian Council on Academic Awards (which endeavours to ensure parity of educational wards across Australia), a diploma differs from a degree, not in length (both require a minimum of 3 years), but in being more vocationally-oriented and having a greater component of practical experience--they are intended to be

equal but different. However, a diploma provides somewhat limited access to postgraduate study compared with the degree and the practice has developed in a number of fields of providing diploma to degree conversion programs, usually by an extra year of full-time study. The nursing profession has generally argued that 3 years is too short for basic preparation, favouring 3.5 or 4 years. With the post-registration degree conversion, this is what they have, but the diploma-degree split prevents the planning of an appropriate degree "from the ground up," thus bedevilling the task of curriculum development. Not all of those graduating with the diploma will go on to conversion programs, particularly as available places in the latter are still very restricted. It has been difficult to prevent the degree conversion year from resembling a postgraduate diploma (also a year long) and thus perpetuating the undervaluing of nursing qualifications which has greatly elongated the educational pathway for nurses in the past. For example, even into the 1980s in NSW, the qualification for nurse teachers remained at associate diploma level, even though the only resemblance to an associate diploma was its length. The problem lay in gaining appropriate recognition within the general educational system for nursing training and experience.

Because of the elongated pathways, few nurse-teachers possessed even the minimal academic qualifications that had become the norm in the higher education sector. The initial move into (mainly) Colleges of Advanced Education was somewhat more hospitable to them, as the vocational orientation of the Colleges led to a greater valuing of vocational education and experience. Even so, nurse teachers who

moved into higher education were struggling with the need to plan and implement a new program, concurrently endeavouring to upgrade their academic qualifications toward the norm. In addition, the heavy practicum component in the programs, requiring small-group clinical teaching and supervision, lifted their teaching loads above the institutional norm. The movement into Universities will exacerbate the pressure to upgrade qualifications in these difficult circumstances, as well as producing an increased demand for publications.

While their relative lack of academic qualifications does not reflect the academic ability of nurse teachers, for the foreseeable future it is likely to remain a handicap to them personally and to the development of nursing as a discipline within the higher education setting. (As students within the institutions, nurse teachers have tended to do very well as mature-age, highly motivated and intelligent people who are the survivors of a very tough system.)

In looking at the NSW curriculum documents, it would be inappropriate, then, to judge them too harshly for not solving problems with which nursing in the USA, with a much longer history in academia, is still struggling. It can be expected that Australian answers will evolve over time, although answers are only ever partial and ever moving toward new answers.

On the positive side, there is probably a considerable advantage in the movement of the entire system to provide one pathway to registration, where the U.S. system is still dealing with three. It seems likely that, in the not-too-distant future, diploma entry to

practice will become degree entry, as in other fields. (A current handicap is diploma entry into primary-school teaching--another large, predominantly female field of employment). But this move, if and when it comes, will be Australia-wide because of federal funding. Because of funding implications, it may well be that the offer will come in the form of a 3-year degree to replace the 3-year diploma. The nursing profession is already debating whether to accept this or to continue to argue that 3 years is not long enough to provide the preparation they deem necessary (see Nursing Education Targets, 1989). The most likely scenario is that they will accept the 3-year degree and continue to argue for its extension to the Health Sciences norm of 3.5 to 4 years (physiotherapy, occupational therapy, speech therapy, etc.).

There is also some advantage, I believe, in the arts and social science degrees nurse teachers have undertaken in the absence of nursing degrees. Many of them have sought to apply the knowledge and understanding thus gained to the field of nursing, because, as nurse teachers, they have remained committed nurses. Their nursing commitment has thus not only guided their selection of courses but has shaped the understandings they have developed through the courses. Their developing understanding of nursing is thus informed by study in other disciplines, often including the epistemological problems which underlie the established fields. They are thus less likely to see the problems of developing nursing as a discipline as unique to nursing.

While this is likely to be a passing phenomenon as nursing degrees become more widely available, it is probably an important one

at this stage of the development of nursing in Australia, as it must have been once in the USA.

There is also advantage in having available the U.S. experience on which to critically reflect, the process of critical reflection being aided by resistance to U.S. "cultural imperialism." In these ways, Australian developments may be interesting for years to come, although in this document, only the beginnings of the process will be examined.

The NSW documents have been chosen because they were produced at the same time against the background of a statewide total shift of the system. The next most populous state (Victoria) is still moving through a more gradual process, still undecided about combining separate registers (particularly general nursing and psychiatric nursing) which NSW has already done. The NSW documents thus provide a reasonably coherent sample.

NSW Background

A number of experiments in basic nursing education in NSW had occurred from the late 1960s on, including combined university degree/hospital certificate programs, shortened nursing programs for university graduates, and pilot programs in Colleges of Advanced Education. These show a similarity to approaches tried at an earlier stage in the USA, as detailed by Harms (1954).

At the same time, the NSW Nurses' Registration Board syllabus expanded in areas of both content and hours and very small schools of nursing were progressively closed. Rationalization was attempted by

regionalization of schools of nursing, particularly in country areas, students from smaller hospitals attending lectures on block-release at a major hospital, or, in the case of the Newcastle region, at the Newcastle College of Technical and Further Education. But the costs of such education continued to be borne by the hospitals who employed the students.

NSW Nurses Education Board

In 1973, the NSW Nurses Education Board (NEB) was set up within the Ministry of Education with an advisory and research role. This was the first tiny step toward shifting responsibility for nursing education from the Ministry of Health to the Ministry of Education. Research conducted under the auspices of the NEB was important in demonstrating the deficiencies, unevenness of provision, and real costs of the prevailing hospital-based system, thus enhancing the impetus for change.

It remained a key player throughout the transfer, although it has now been disbanded. At a less formal level, it played a key role in influencing the NSW Higher Education Board (also now disbanded) which had oversight of higher education in NSW. Both Boards were situated in the same office building (geography counts!) and patterns of formal and informal consultation developed. As a result, executive members of the Higher Education Board (HEB) become sensitized to the needs of nursing. On a visit by the HEB to Armidale College of Advanced Education in December 1984 (where I was present), the questions they were raising were: "How can we best ensure the development of nursing

as a strong academic discipline?", "How can we build up academic leadership in nursing?", "How can we ensure that future academic leaders coming through the diploma program can get their degree and proceed to postgraduate study?"

In the late 1970s and early 1980s, the NSW NEB had also been instrumental in the setting up of regional nursing education advisory committees which were to advise on how nursing education should develop in their region. This had the important educational effect of bringing together Chief Executive Officers of Hospitals, Directors of Nursing and nurse clinician representatives with representatives of educational institutions to consider problems and possible solutions on the assumption that the situation could not simply be allowed to drift. In an important sense, this paved the way for the transfer, as all committees recommended some form of transfer to higher education.

With the transfer decision, the guidelines issued to Colleges under the imprimatur of the NSW Higher Education Board were largely prepared by the NSW NEB.

NSW Nurses Registration Board

A crucial factor for the curriculum in the NSW transfer was that the NSW Nurses Registration Board (NRB), a statutory authority within the Ministry of Health, was planning to have its act changed to allow for one register along with the move into the higher education sector. The pilot programs had been for general (medical-surgical) registration only.

There had existed in NSW five basic registers, accessible through

different training programs with different syllabi. These were the General, Psychiatric, Mental Retardation, Geriatric, and Mothercraft Nursing Registers. What was proposed was a single register which would allow new graduates to function as beginning practitioners in any of these areas. In addition, the NRB wanted the college courses to provide a grounding in community health, including health promotion and education.

Early in 1984, the NRB issued a statement setting out their "philosophy" concerning a basic nursing programme, clarified their expectations about a number of matters, and listed the competencies expected of a first-level practitioner (NSW NRB, 1984). The bulletin of the State Planning Group for the Transfer (SPG) described this document as constituting "an authoritative profile of the diplomate colleges sould (sic) be aiming to produce" (SPG Bulletin, April 1984, p. 3).

The NSW NRB was also anxious to avoid the need for a licensing examination in order to bring nursing in line with other professions in Austalia, where graduates of approved programs are qualified for registration. The registering authority thus accredits the institution, rather than the individual student.

However, in this document, the NRB stated,

> 7. The Nurses' Registration Board reserves the right to assess candidates for registration by examination except where exemptions apply. Consideration will be given to exemptions where the Board is satisfied through its involvement in the course preparation and assessment of progress of students through the course that the outcome is satisfactory. (NRB, 1984, p. 2)

The NRB guidelines thus had considerable power, since no institution wanted to be placed in the position of their graduates having to sit a licensing examination while the graduates of other institutions did not. The threat may, however, have been more perceived than real because of the work that would have been involved in adapting the bank of multiple-choice questions to the new single register to cater for one or two institutions.

The State Planning Group for the Transfer of Nurse Education

Known in short as the State Planning Group or SPG, this was an interdepartmental committee set up in November 1983 by the NSW Minister for Education, with representatives from Education, Health and Treasury. Of the nine members, four were nurses (two from Health and two from Education). As described in its second bulletin, it major task was,

> To develop a detailed work flow plan with target dates for the transitional period to ensure the successful commencement of nursing training in Colleges of Advanced Education by the beginning of 1985. (SPG Bulletin, February 1984, p. 1)

Its brief, spelled out in more detail in the same document was a wide one, including allocation of student numbers to each institution, allocation of hospitals to educational institutions for clinical experience, transfer of funds from the hospitals to the educational institutions, identification of needed changes in the Nurses Registration Act, and "any other matters that might arise."

The transfer involved, among other things, the transfer of

buildings and equipment used by hospital schools of nursing. Those without firsthand experience of nursing education were shocked by the paucity of this inheritance and it brought home to them in a very concrete way what the nursing profession had been complaining about for years. The capital sums needed to bring these facilities up to mainstream educational standards rapidly escalated. The use of these buildings, on the whole, remained unsatisfactory and they are being replaced by new on-campus buildings as funds become available.

As part of its function, the State Planning Group sponsored workshops for a number of major nursing interest groups, which addressed themselves to developing guidelines in their special interest areas for the new courses.

In October 1984, at their invitation, I visited the NRB to discuss developments with Maureen McGrath (Executive Secretary) and Betty Hall (Nurse Education Officer) who were also on the State Planning Group. They believed that the workshops had been highly productive, not only in hammering out sets of guidelines and realistic expectations, but in convincing waverers of the feasibility of the project, disseminating accurate information into the nursing "grapevine" and giving practicing nurses a chance to "air their views." However, as they themselves acknowledged, since workshops were more easily attended by those in the Sydney metropolitan areas, the results were somewhat diluted in country areas!

Summary

The transfer of initial nursing education in NSW, after years of agitation and political lobbying by nurses, in the end took place with breathtaking speed. From the initial government announcement in November 1983 to the initial intake of first-year students in late February-early March 1985 (the commencement of the Australian academic year), educational institutions had less than 15 months to recruit senior staff, write their curricula, have them approved, recruit more staff, adapt or build teaching facilities, and recruit and select students. In this rushed timetable, curricula had to be written ready for accreditation by mid-1984, so curriculum development was not carried out at a leisurely pace.

But whatever the educational institutions may have lacked, it was not advice--sometimes confusing, often contradictory. In summary, the educational institutions received, with regard to the curriculum,

Guidelines from the NSW Nurses' Registration Board

Guidelines from the NSW Higher Education Board (written in close consultation with the NSW Nurses' Education Board)

Guidelines from special interest groups

(There were also numerous other commands/advice with regard to other matters--couched in terms not to give offense to the "autonomy" of the educational institutions.)

The NSW NRB and NSW NEB were also represented on the curriculum development advisory committees at each institution, in addition to representation from the health region and its training hospitals.

Non-nurse representatives from within the institution concerned

also had their interests in preserving institutional autonomy and in building up their own departments by gaining a share of the curriculum in a move which would increase the student population of the Advanced Education sector by 25% over three years. (Nurses were to become the second largest group, after school teachers, to be prepared in these institutions.)

The integration of the four registers also resulted in a certain amount of confusion, as there was no clear model at hand for its working out in practice, although there was a strong belief that it could be done, based on the New Zealand partial transfer into Technological Institutions. Special interest groups, particularly those in psychiatric and mental retardation nursing, were anxious that their areas should receive "equal" treatment, whatever that might mean.

Where one senior nurse academic with strong ideas was able to provide the leadership necessary to pull these various interest groups together and write the curriculum document, a reasonably coherent curriculum tended to result. Otherwise, the timeframe was far too short to allow for a more consensual form of curriculum to emerge in a coherent way. By and large, the strongest curriculum documents represented the ideas of strong-minded senior nursing academics, able to argue their case convincingly to their advisory committees. The more confused and less coherent documents emerged from endeavours to take more seriously the process of consultation and "democratic" decision-making, within the short timeframe available.

CHAPTER VII

CURRICULUM DEVELOPMENT AND NURSING KNOWLEDGE IN THE USA

In very broad and general terms, the transfer of basic nursing preparation from the hospital training school to the higher education sector could be seen as a move away from the British model toward the preferred North American model. Both British and United States nursing literature is widely used in Australia, so that Australian nurses in leadership positions are well aware of both systems, at least as reflected in their literature. But, in addition, Australian nurses have quite commonly worked and/or studied in either or both countries, nursing qualifications having long been regarded as a "passport" to overseas working holidays, favored destinations being the United Kingdom, Europe, the USA, and Canada.

Australian nurses, like Australians more generally, are ambivalent about overseas ideas but, inevitably, are influenced by them, adapting them to Australian conditions with varying degrees of difficulty. In many fields, of which nursing is one, the home-grown literature is very sparse, reflecting both the relative smallness of the book and journal market and the relatively small number of Australians well enough educated in the field to produce the local literature. Although this situation is gradually changing, for the foreseeable future Australians will continue to rely on overseas material which varies in its appropriateness to the Australian situation--a matter of which students frequently complain.

Of course, this is not a problem for Australia alone. Academic publishing is increasingly an international marketplace and, in a specialized area such as nursing, books and journals, particularly those beyond the basic textbook level, need to be of general enough interest to have an appeal beyond the limited marketplace of small countries like Australia. In the Australian case, not even a language barrier provides partial protection from the dominance of the U.S. literature in nursing.

It is thus important to consider the U.S. literature as background for understanding the way that nursing knowledge was structured in the NSW curricula considered here.

The U.S. Background

According to Murdock (1983), prior to 1950 the nursing knowledge component of U.S. curricula was based largely on the medical model with its main focus on disease and its control and a supplementary focus on technical skills, environmental control, and professional "ethics." This is probably the closest approximation to the pre-transfer registering authority imposed curricula in Australia, although there had been in recent years attempts to move away from such a focus which varied between states.

During the 1950s and 1960s, other structural forms appeared, classified by Stevens (1971) as:

1) Logistic--structured by disease, body systems or patient care area.
2) Operational--structured according to perceived

learning needs of the students, with case histories in common use.

3) Problem-centered--influenced by Abdellah (1960), focused on the act of inquiry or problem solving.

4) Dialectical--structured around some synthesizing whole such as lifespan development or health-illness continuum.

I would be doubtful whether, in practice, any of these were found in their pure form, and certainly elements of them appeared in more recent registering authority imposed curricula/syllabi in Australia.

From the late 1960s on, there was increasing interest in building conceptual frameworks to guide practice and integrate curricula (Murdock, 1983, p. 19). In 1972, the National League of Nursing (NLN) made a conceptual framework a requirement for its accreditation (NLN, 1972), and this was iterated in 1977 (NLN, 1977). In a study of the conceptual frameworks of baccalaureate nursing programs accredited by the NLN in 1972-1973, Torres and Yura (1974) identified the major concepts used as man (sic), society, health and nursing, although the degree of development and relative emphases varied as did the identification, classification, and development of subconcepts such as illness and wellness (health) and nursing process, nursing role and nursing functions (nursing). Almost all programs claimed to use "the nursing process."

Santora (1980) reports an unpublished study by Tiedt which surveyed 68 curriculum coordinators/chairpersons of baccalaureate programs about conceptual framework elements. There was strong or

very strong agreement on the importance of including:

1) Nature of nursing and the delivery of nursing care.
2) Nature of the teaching-learning process.
3) Nature of man (sic), death and health care delivery.
4) Role of giver and recipient of health care.
5) Goals of nursing action.
6) Focus of intervention.
7) Responsiveness to society's current and changing needs. (Santora, 1980, p. 9)

However, this is extremely general and any number of approaches could be encompassed under these headings. They provide little insight into how those surveyed would actually structure nursing knowledge, let alone the total curriculum.

In a survey of NLN accreditation returns (1972-1978) for schools offering both baccalaureate and masters degrees in nursing, Santora (1980) classified the conceptual frameworks that were reported as being used in each program. According to her very literal criteria, 32 out of 61 were using none, ambiguous or multiple frameworks. Apart from these, the most popular framework was adaptation (20), followed by systems (8), and developmental (1). Thirteen (13) of those using multiple frameworks were using adaptation as one of them, so that over one half (33) were using adaptation, making it the most popular choice. There were nine commonly used concepts--man (sic), nursing, nursing process, health, illness, family, community, social systems, and environment. These are similar to what Torres and Yura (1974, above) identified as subconcepts under their major headings of man (sic), society, health, and nursing with the addition of environment which probably reflects the widespread use of adaptation and systems

as frameworks.

The results appear to reflect developments in the nursing theory literature which were to lead to the identification of a very broad and general nursing focus, which was identified as a "metaparadigm" when nurses discovered the work of Thomas Kuhn (Chinn, 1983; Flaskerud & Halloran, 1980; Newman, 1983). The popularity of adaptation and, to a lesser extent, systems as frameworks can probably be related to the publication of the first edition of Riehl and Roy's book (1974), significantly called Conceptual Models for Nursing Practice which was very much oriented around systems theory and adaptation frameworks. Although other writings on nursing theory existed, Riehl and Roy's casting of their ideas in the form of models probably made them seem closer to the "conceptual framework" curriculum developers were seeking.

Hall (1979) also conducted a survey to identify conceptual frameworks in 1977, using a questionnaire. Her results are poorly reported, but suggest that almost half the baccalaureate programs were using the work of one or more identified nursing theorist, although not in unmodified form. Again, stress-adaptation and systems models appeared to be popular. Some schools, however, claimed to be using non-nursing theorists.

The literature of the time period under discussion suggests that there was considerable confusion about what a conceptual framework entailed, as numerous articles appeared in NLN publications and elsewhere endeavouring to clarify the differences between philosophies, conceptual frameworks, and theories. (See, for example,

Kelley, 1975; Reilly, 1975; Chater, 1975; Bevis, 1973, 1978; Peterson, 1977; NLN, 1978; and Freisner, 1981.) More recently, Adams (1985), a Canadian nurse, has gone back over similar ground.

Although Chater (1975) discussed a three component model--setting, student, and subject, most nursing attention appeared to focus on a framework for developing an integrated approach to nursing knowledge, that is, subject concerns. While this reflected perceived NLN concerns, it also represented the searching for something to put in place of the discredited "medical model" or what Stevens (1971) called the logistic framework centered around disease classifications, body systems, and/or health care agency geography.

Styles (1975) agreed that an accurate perception of integration prevailing among nurse educators was that articulated by Torres, that is, "blending the nursing content in such a way that the parts or specialties are no longer distinguishable" (Torres, 1974, p. 2). Although Styles had reservations about the way integration was being used to cast out the devil of "the medical model," arguing that the purpose of education was <u>to assist the learner to integrate</u>, there is some merit in Pennington's (1986) argument that it was successful in focusing nursing toward the development of a distinct perspective of its own.

> Although it is not specifically stated as such, I believe the purpose of the integrated approach to curriculum was to (1) identify independent nursing knowledge (different from medical knowledge), (2) conceptualize nursing in order to test and expand the development of nursing theory, and (3) separate generalist knowledge and practice from specialist knowledge and practice. (Pennington, 1986, p. 38)

One can, of course, argue about the extent to which this was successful. Nursing was focused away from "the medical model," but it is by no means clear to what it was focused. Testing and expanding nursing theory (which one?) remains a problem--a framework that may do for organizing nursing content may not necessarily be a useful framework for research (and vice versa). The separation of generalist from specialist knowledge does not itself solve the problem of what the nursing specialties (as distinct from medical specialties) should be. (Williamson, 1983, found 130 Masters specialty titles in nursing in the USA, following different models--medical, life-stage, time, and health-illness being the main groupings. An NLN publication (1986) has also recently focused on the issue.)

Pennington (1986) claims that "one of the most impelling developments in the nursing curriculum has been the move toward integration" (p. 37), yet, on her own admission, there has been little integration in or with the general education or support courses. In the nursing baccalaureate, integration has generally been restricted to nursing content. Other more established disciplines have apparently resisted integration even with cognate fields, and it seems likely that Pennington is right that "integration" was used to pull nursing away from "the medical model" and attempt to force-feed its development as an independent discipline.

Thus, "integration" can be understood as being directed at development of the discipline rather than facilitating student learning (which was Styles', 1975, concern). Welch and Slagle (1980) argue that,

> The primary result of a conceptual approach to nursing curricula may be that nursing faculty rather than students integrate nursing knowledge. It does not necessarily follow that the approach used to help nursing faculty integrate content will help nursing students integrate content. Faculty often forget that they come to the process of integrating concepts with a large knowledge base in nursing. Nursing students, too, need to be given a knowledge base so that they can then integrate this knowledge and then generalize from their integrated knowledge base. (Welch & Slagle, 1980, p. 39)

However, if knowledge is to be "given" to the student, it cannot be in the form of disembodied facts--some concepts will shape the knowledge that is given. The model of teaching-learning that Welch and Slagle seem to have unconsciously adopted is that of the students soaking up material like a sponge until, at a certain point of saturation, they start to organize it for themselves, turning it into the wine of integrated knowledge. This is not to deny that students actively unpackage the curriculum content, however organized, and organize it in a way that makes sense to them on the basis of previous learning and experience. This will not be explored here, other than to make the point that the general inattention to such issues suggests that "the integrated curriculum" was more a matter of meeting professional aspirations than student needs.

In 1982, the NLN changed its language from "conceptual framework" to "organizational framework," at the same time insisting that the curriculum focus on "the discipline of nursing," thus continuing the preoccupation with organization of the knowledge base.

To this point, the thinking briefly reviewed here shows considerable continuity with the advice issued to NSW Higher Education

Institutions in 1984 by the NSW NRB, and NSW HEB (Basic Nursing Education and Basic Nursing Education: Guidelines for Advanced Education Institutions in the Preparation of Courses respectively). The former listed a set of competencies which they expected of graduates and the latter provided a recipe for course development, which "should have the discipline of Nursing as their core" (NSW HEB, 1984, p. 1).

As Diekelmann (1988) points out, the background assumptions about the educational enterprise are based on the Tyler (1949) model, and, in particular, on its means-end philosophy. If we decide the goals to be achieved, it is believed that it is possible to formulate and organize educational experiences to attain those goals and that this attainment can be measured. It is an industrial-technological model of the educational enterprise and its appeal to nurses is understandable, given the apparent self-evident nature of the need to prepare nurses for a particular vocational niche. The curriculum thus becomes a production line along which students pass and the aim of curriculum change becomes to increase the efficiency and effectiveness of that production line. Rather than a better mouse trap, the goal is to make a better nurse.

At the same time, there is a twist to the story. Because of the nursing leadership's disenchantment with the "doctor's handmaiden" supportive role it was pushing the development of an independent profession, for which they believed a body of unique knowledge was required. Thus, as I have been arguing, the production line was also about the production of a unique knowledge base, and this appears to

underlie demands for "a conceptual framework" and "an integrated approach," which could be seen as running in tandem and interacting with the nursing theory movement. Thus, it appears to be no accident that the four concepts identified by Torres and Yura (1974)--man (sic), society, health, and nursing bear a close relationship to the nursing "metaparadigm"--person, environment, health, and nursing--which is now almost ubiquitous in the literature.

In addition to the link I have suggested between Santora's (1980) findings and the first edition of Rhiel and Roy, there are a number of other links that are more explicit. As recently as 1986, Pepper suggests curriculum organizers drawn from nursing models, using Rogers, Peplau, Neumann, Roy, Orem, and Johnson as examples, and Flaskerud (1983) advises developing a curriculum based on a nursing conceptual model.

Fawcett (1984), in an article titled "Theory: Basis for the Study and Practice of Nursing Education" focuses on "nursing's metaparadigm, conceptual models and theories." Despite the very general title, the focus is exclusively on the nursing theory literature rather than, say, educational theory, demonstrating again the preoccupation with the shaping of nursing knowledge.

Earlier, Derdearian (1979) had made this link explicit, in an article tellingly titled "Education: A Way to Theory Construction in Nursing" in which one of her aims was "to test the validity of the premise that education can be a means to theory development in nursing" (Derdearian, 1979, p. 36). Not surprisingly, she reaches the conclusion that,

> Nursing education, based on nursing conceptual frameworks, seems to contain the direction toward identifying nursing goals commensurate with their philosophies and theories lending consistency and constancy to individual and collective practice, research and education.... [C]ommon goals commensurate with nursing models identified ... as directing education, practice, research are crucial in the development of nursing theory and science, and, eventually, to the development of nursing's identity. (p. 36)

In this example of nursing "newspeak" which almost defies translation, I think she is saying that she has proved her premise--a very circular argument.

In an early critique of these developments, Styles wrote,

> In earlier days, we "incorporated" selected content ... into the traditional medical model curriculum; today we have moved to the adoption of frameworks around which we endeavour to weave the whole cloth.
>
> In the interim, curriculum projects proliferated, and task forces the world over labored to identify and elaborate processes, concepts, strands, and themes which would be sufficiently comprehensive, yet sufficiently specific to the practice of nursing.... The result is a few major patterns with myriad variations ... all spelled out in diagrams, called models or systems, often resembling very complex electrical circuits. (Styles, 1976, p. 739)

But she seems to have been "a voice crying in the wilderness" and it is relevant to ask why. The amount of labor expended can perhaps best be understood by the desire to re-make nursing rather than to develop a curriculum as such. Common sense should have informed us that our adult students are certainly not tabulae rasae, and that no two students therefore experience the same curriculum. The more tightly structured the curriculum, the less it is able to encourage individualized learning and learning styles. Nursing students thus

learn through the "hidden curriculum" (Illich, 1971) the standardized procedures of the health care system, despite an overt emphasis on "individualized patient care." It also makes it harder for students to claim credit for previous learning and experience which was structured differently--a problem that has arisen with fitting RNs into the standard pattern in NSW, and which also complicates student transfer.

It is also one thing to produce a diagram of a "very complex electrical circuit" and quite another to develop a curriculum which accurately reflects its wiring--and this can certainly be seen in the NSW curricula which are the subject of this study. It seems that the further one moves from the broad outline to the detail, the more content resembles that found generally in nursing curricula, and this should not surprise us. It may account for the general inability to show that any one curriculum model is superior to any other (for example, White, 1983, pp. 180-184), although it may also reflect the notorious difficulties of curriculum evaluation.

It should not surprise us because nurse teachers are primarily nurses with a deep contextual understanding of what nursing is about and the sort of things that nurses need to know and understand for safe and caring practice. As Benner (1984) argues, this can never be completely explicated. Even if the curriculum document did accurately reflect the "wiring of the circuit," the implementation is highly unlikely to do so, because nurse teachers teach from their own sense of salience. (In general education, the quest for "teacher-proof" curricula has been abandoned.) Some form of organization to provide

breadth and reduce unnecessary overlap appears useful, but it needs to be a facilitating, rather than an imprisoning one for faculty and students.

Despite the ongoing literature of at least 15 years, Pennington in 1986 still thought it provocative to suggest,

> Baccalaureate nursing curricula should be integrated so that the focus is not on the traditional "medical model" specialties but on the process concepts leading to generalized practice. (Pennington, 1986, p. 133)

This makes one wonder just what had been really going on all those years! Perhaps the integrated curriculum based on a nursing conceptual framework was more theoretical talk than practical substance. Certainly, with the exception of White (1983), there is little detailed material on its implementation in practice. Yet this is the literature to which Australia turned in planning its move out of the hospitals into educational settings.

For the reasons above, I am choosing to look at the NSW curriculum documents which are the subject of this study as a continuation of the USA enterprise, that is, primarily an attempt to re-think nursing. This is not without its value, particularly for faculty reorientation, but, I would argue, needs to be recognized for what it is. It is not primarily about students, but about the form that nursing knowledge should take.

Recent USA Developments

Rather too late to affect the NSW developments examined here, a more critical body of thought--a self-termed "curriculum revolution"--involving a rejection of the Tylerian model is emerging. It involves critique of the NLN accreditation guidelines and, since it provides a way of critically examining the NSW guidelines, it will be reviewed briefly here.

Diekelmann (1988) basically argues that NLN accreditation criteria, based on Tylerian principles, have straitjacketed the development of nursing and the nurse as learner. She argues for a view of curriculum as ongoing process, the model appearing as a guide rather than recipe. She contends that the assumptions of the pervasive Tylerian model in nursing are that,

1) Information from the classroom can be unproblematically transferred to practice, leading to the endeavour to match classroom teaching with clinical experiences (the so-called integration of theory and practice).

2) There are some essential knowledge and skills which all students must acquire.

3) All students ought to have experience in every specialty area of nursing, or at least as many as possible.

By contrast, she claims that "phenomenological models of curriculum emphasize the processes of understanding that shape the world of the student and teacher" (Diekelmann, 1988, p. 142). As such, I assume they would need to take account of the "hidden curriculum"--an example of which is provided above--since emphasis is on the importance of experience and meaning. Clinical experience becomes a way of

introducing students to the clinical world, rather than a setting for evaluating their classroom and laboratory learning. Their experience of the clinical world then informs their classroom learning which takes place by the initiation and maintenance of dialogue which makes and gives meaning. The teacher-as-learner tries to understand the lived experiences of their students as well as their patients, and seeks ways to link the contextual and conceptual worlds of the students.

Curriculum is thus seen as "the lived experiences of students, teachers, and clinicians as they work together to understand how best to introduce students to the practice of nursing" (p. 144).

Since Diekelmann is currently researching the lived experience of nursing students and teachers, she is not claiming that this is a completely new approach. Rather, she sees it as the way expert nurse teachers already do function when they are at their best. Her argument is rather that our technological understanding of curriculum, like the formal structures of the health care system in the case of nursing practice (Benner, 1984), has impeded rather than facilitated the development of teaching excellence. She sees teaching as a field of nursing practice as worthy of study and research as any other, claiming that nurse teachers function as nurses teaching, rather than as teachers with a nursing background. In this way, she relates her research to the work of Benner (1984) on expert nurses.

Diekelmann, Allen, and Tanner (1989) have carried out a critical analysis of the NLN guidelines, the section of the paper written by Diekelmann and Allen subjecting some of the key criteria to

hermeneutic (interpretative) analysis, including the requirement of an organizational framework (formerly conceptual framework). They argue,

> A constitutive pattern that emerged is captured in the analogy of curriculum as tinker toy. This metaphor applies to the instrumentalist view in which knowledge is seen as additive.... But the tinker toy metaphor also reflects the Tyler model in which the curriculum is described as parts to be organized and controlled. Even the teacher centered pedagogy reflected in the criteria is consistent with a view of the curriculum as building something with the teachers as master-builders or contractors, if you will. (Diekelmann, Allen, & Tanner, 1989, p.)

"Contractor" seems a more appropriate metaphor, since many nurse teachers move into teaching slots in an ongoing curriculum. The "curriculum revolution" is thus about freeing nursing curricula from its more rigid external constraints, so that they can develop in dialogue between teachers, clinicians, and students. The curriculum thus becomes an ongoing process of becoming. This is more than saying that curricula develop and change over time, because this tends to happen in a lockstep fashion, by means of curriculum review. Rather, at every moment the curriculum is coming into being, as teachers, clinicians, and students in dialogue create and are created by their world.

Again, this can be recognized as a phenomenon we know as nurse teachers. But the point is that this process can be impeded by the existence of a rigidly structured formal curriculum with its familiar paraphernalia of checklists and assessment tools (which parallel the similar paraphernalia of the practice setting).

But if, as I have suggested, the conceptual/organizing framework

game has really been about structuring nursing knowledge rather than facilitating student learning as such, then the "curriculum revolution" can be seen in the context of another incipient revolution in the consideration of nursing knowledge. This is why, I would suggest, Diekelmann, Allen, and Tanner find kinship with the work of Benner. To the extent that one no longer believes that nursing knowledge can be captured within a logico-empiricist framework, then it becomes less likely that that sort of framework will be seen as appropriate for the curriculum.

However, there is also a move toward increasing formalization of the nursing knowledge base, with the further development of nursing diagnosis categories and the delineation of appropriate "treatments" according to diagnosis. The assumption appears to be that the model which worked for doctoring will work for nursing, doctoring being a particular way of applying the body of knowledge we call medicine. The nursing diagnosis and treatment approach is likely to be associated with a highly structured curriculum in order to cover the diagnostic categories and treatments. I would predict, therefore, that to the extent this approach becomes the accepted one, the "curriculum revolution" will fail.

To put it more positively, the "curriculum revolution" and the reconsideration of nursing knowledge originally suggested in the work of Benner (1984) are mutually dependent, or could be considered rather part of the same "whole." They are both symptomatic of a dis-ease with the endeavour to fit nursing practice into the dominant logico-empiricist framework, which many feminists have argued is an

inappropriate structure for knowledge which has its prime origin in the female world of connectedness. Indeed, it could be argued that the scientific framework worked for medicine to the extent it did because nursing was there to provide the sort of care that the medical model omitted.

As Ehrenreich and English argue, the scientization of medicine occurred in tandem with the development of a capitalist economy, increasingly packaging healing as a commodity. But, they argue,

> Herein lies the contradiction that haunts regular medicine today: Healing is not something that can be easily bent to such a form; it involves too many little kindnesses, encouragements and stored-up data about the patient's fears and strengths. It cannot be quantified.... Above all, it cannot be plucked out--as a thing apart--from the web of human relationships which connect the healer and those she (sic) helps. (Ehrenreich & English, 1978, pp. 39-40)

Although to the extent that nursing became "the physician's hand" (Melosh, 1982), it partook of the same scientization and commodity relationships, it has always insisted, from the time of Nightingale on, that it was "something more." As I see it, it picked up much of what could not be accommodated within the scientific approach to medicine. Therefore, to the extent that nursing scientizes itself, new gaps will open up in the web, necessitating the development of a new group of workers in the public domain (whatever they will be called).

However, the guidelines issued to higher education institutions in NSW in 1984 exhibited, although in a milder form, the same type of approach as the NLN guidelines in the USA and are thus open to a similar critique.

CHAPTER VIII

THE RESEARCH APPROACH

Since hermeneutics was a term originally given to the interpretation of canonical texts that were puzzling, the application of a hermeneutical approach to the nursing knowledge component of a set of nursing curriculum documents seems peculiarly appropriate. The hermeneutical set of techniques were originally designed to uncover the message from God which it was believed the texts contained (Packer, 1985). The term was later generalized to apply generally to textual interpretation and later expanded to the interpretation of human actions as texts (Dilthey, trans. Rickman, 1987; Taylor, 1984).

The major alternative to the interpretative approach taken here is content analysis (for example, Torres & Yura, 1974; Santora, 1980). Content analysis in these studies is carried out at the manifest level, involving classification of concepts used according to some code. (The findings of these studies are reviewed in detail in Chapter VII.) This is a quantitative approach which measures reliability in terms of intersubjective rater agreement and validity in terms of sampling design and content validity, the latter being established through "informed judgment" (Santora, 1980).

The content analysis approach assumes that words (or phrases) are context-free entities that can be classified according to a grid. Conceptual frameworks and concepts are equated unproblematically with the use of key words and phrases. This approach vastly oversimplifies human use of language and, to refer to the original meaning of

hermeneutics, has similar problems to literal interpretation of the Bible. It is in context, interpreted broadly, that words, phrases, and even sentences make sense. That context includes temporality, the situation, and the "speaker." To the extent that the manifest content analysis approach works, it does so to readers who share a common background, that is, who are situated in the modern world of academic nursing in the USA (and, by extension, readers like Australians who have become knowledgeable about that background through the literature). Even so, it is an approach which provides little in the way of understanding. The how and why questions remain unanswered, buried in the assumed background of the reader.

This assumed background is therefore covered over--does not show up--in a manifest content analysis approach. Content shows up as decontextualized elements, abstracted from their interrelationships and therefore stripped of the meaning that resides in such interrelationships. Santora rejects latent content analysis, which was a possibility inherent in the data base (conceptual frameworks submitted to NLN), because of its problems with reliability and validity. Thus understanding is sacrificed for reliability and validity, as is often the case in quantitative approaches.

Also covered over are intents, configurational knowledge, and taken for granted background meanings which are not amenable to a study of content alone but require one to draw on one's situated understanding. While this background can never be fully explicated--made totally visible--ignoring it (as the content analysis approach tries to do) leads to a very limited forms of understanding. As

Falconer and Williams (1985) argue,

> A genuinely scientific human science must seek understanding. Its object is not so much progress as it is maturation and continued understanding. Its goal must be truth (temporal articulation), not certainty (atemporal objectification). (p. 1187)

The manifest content analysis approach can be seen as an attempt at atemporal objectification--the identification of people in a snapshot might be an appropriate analogy. Yet even such identification is not interpretation-free or context-free. Rather, the person identifying the people in the snapshot relies on a shared understanding of, for example, who Aunt Martha is and the significance of the setting (time and place). Without such understanding, the snapshot is meaningless, opaque to our understanding, lacking in significance. Thus, understanding the snapshot depends on "temporal articulation" in the sense of an understanding of history, of time and place and people and ideas involved.

But Falconer and Williams refer to something more than such historicism (which they critique). Following Heidegger (1962), they see temporality as residing in the givenness and openness of the situation, in having both content and direction. While snapshots may, with adequate interpretation, convey the givenness, they fail to capture the openness--the active and possible. A more appropriate analogy than the snapshot might be the sort of journey where the goals remain fairly general and possibilities (in the form of alternative routes) are limited only by present position (which is the outcome of past positions) and the fairly general goals which direct the journey.

A hermeneutic approach, understood in this way, attempts to provide an understanding of past and present positions in such a way as to open up possibilities for the future of the journey. The truth of a hermeneutically developed understanding therefore depends on its cogency, understood as its coherence with our general understandings of the world together with its ability to increase that understanding in such a way as to open up a range of possibilities to us.

Atemporal objectification, in aiming for certainty, produces an evanescent sort of truth which vanishes as the context which gave rise to it changes. Like the snapshot it resembles, it loses its hold on the present as events recede into the past.

This is not to claim a truth for hermeneutical understanding that is immune to the ravages of time (that is ahistorical). But a well-developed hermeneutical understanding provides the basis for ongoing understanding, for further interpretative development and redevelopment, as further events unfold or past events show up in new ways.

Thus, my study of the NSW curriculum documents has been a process of an unfolding understanding which is still far from complete, and which I have had to accept will never be complete, because there will always be new angles that present themselves, but that is in the nature of the hermeneutical enterprise. It has also been a maturing experience, as I have put aside as much as possible the hermeneutics of suspicion to concentrate on trying to gain a better understanding of the situation. By this, I mean that I have taken the position that the framers of the guidelines and documents were and are intelligent

people of good will, endeavouring to make sense of nursing in a very confused and confusing situation. There is no way I can lay claim the high moral ground over them--indeed I am one of them.

In developing the degree of understanding I have, my position has been one of situated participant as distinct from participant observer. Although not present during the original development of the curriculum document at my own college, I became deeply involved again in my own employing institution and in NSW nursing on my return to Australia in September 1984. I have indicated the nature of my involvement where immediately relevant, but there is a general involvement in the situation which goes for beyond that. In a very important sense, it is my world. I share its background understandings and meanings, its sense of a common history. The people who framed the documents have been and are in the main, colleagues and/or friends, some of them for many years. I was not coming into the situation from outside that world, nor am I able to leave it on completion of the study.

While this is usually considered to present some difficulties for "objectivity," they can be overstated. As Packer (1985) argues,

> Social action is understood by people in a manner that is influenced by their own interests and projects and is just not available in the same way to an objective, detached and disinterested observer (indeed, from the hermeneutic point of view, such a stance is not possible). (p. 1086)

It is part of the task of participant observation to gain access to the understandings and meanings which a situated participant already has. There is, however, the challenge for the situated participant of

making visible those meanings and understandings, which, in my experience, comes about through the process of making them visible to others outside the situation. But situated participants will always know far more than they can possibly tell (Polanyi, 1959).

This can be illustrated by my numerous attempts to write a historical background to set the context of this study. Imagining a reader ignorant of Australian nursing and Australian politics, I initially tried to spell out all the connections that I understood so well, until the effort threatened to overwhelm the whole project and become a study in its own right. The more I endeavoured to explain, the more other things opened up that seemed in need of explanation. When the ridiculousness of trying to recreate for the reader my own situated understanding became clear, I wrote the chapter back, using a fairly stict "need to know" criterion, allowing an occasional side trip into the interesting, but not essential. Researching the area from scratch would have been less problematic, because I would have access to a much more delimited set of material.

While it is true that most researchers learn more in the course of a research project than they can reasonably report, the problem of what and how much to report becomes particularly acute for the situated participant. In comparison with the participant observer, there is a qualitative difference involved in <u>being</u> part of the world, rather than <u>becoming</u>, for a period of time, part of the world.

There is a problem that arises from the tendency to experience the world as ready-to-hand, from simply being able to function unproblematically in it, so that, in an important sense, one does not

really see it--one simply lives it, and, certainly, at the time, that is what one does. One lives in the ready-to-hand, dealing with the problems of the unready-to-hand (of which there were an abundance because of lack of development of precedents). But, as human beings, we also reflect on our experiences in what Heidegger calls the present-at-hand mode, creating understandings for ourselves and others, although the degree to which we elaborate and strive for consistency among such understandings varies.

If this were not the case, it would be impossible to research the sort of everyday world in which we are all situated participants. We may well live our lives forward and understand them backwards, but whatever understanding we are able to create relies on our ability to reflect on our experience.

This suggests a continuity between research and everyday understanding which I would certainly not reject. Popper (1959) refers to science as common sense writ large, and there is an intuitive appeal in this. We are, after all, making use of the same familiar ways of making sense of the world, but following through more rigorously and systematically than we usually have the occasion to do in everyday life.

The only real test of the understandings reached is the scrutiny of peers. The sources that I have used are, for the most part, freely available. I am happy to admit that my understanding of those sources may be selective and partial, although I have striven to make it as representative as possible. This is only to say that other understandings could be built up--other stories told--upon the same

terrain.

At a more meaningful level, as I have argued, the test of an understanding is its cogency--its ability to make sense and to open up new avenues of understanding and new possibilities.

The transfer of nursing education from the hospital-based training schools in my home state of NSW, with the concomitant requirement for curricula to be developed, seemed to present a coherent opportunity to look at what Australian nurses would do with nursing knowledge. I have to admit to a rather optimistic hope that new eyes considering the problem would yield new insights. In the event, curriculum documents were drawn up in such haste that this was an unrealistic expectation.

The NSW documents seemed an appropriate sample, as they were all developed during 1984 within a reasonably similar context. NSW is also the largest state in terms of population and would provide 15 documents. The next largest state (Victoria) commenced its change-over later and has adopted a gradualist approach, compared with rapid change-over in NSW.

I had originally thought to interview those who had developed the documents, although I was never really clear about why--perhaps in the hope that such interviews would illuminate the documents further. However, I returned to Australia to find a lot of angry people, upset about reports of accreditation committees. The one interview I attempted turned into a ventilation of anger and frustration, interesting if one was looking at the dynamics of curriculum accreditation, but not really central to my interest. As time passed,

I began to think that it might be better to let the documents speak for themselves. I became more of this opinion after another nurse researcher used the Delphi technique to survey heads of school about nursing theory (Emden, 1988). She uncovered a very confused picture which she has eventually understood by placing her delphi results and the selected interviews which followed them in the context of interviews with people from other disciplines who were saying similar things. There was also another less formal interview project underway in NSW and questionnaires beyond number. The journey to the oracles was becoming a well-worn route!

It is some comfort that Webb, Campbell, Schwartz, and Sechrest (1966) lament the overdependence of social science research on interviews and questionnaires, arguing that,

> They intrude as a foreign element into the social setting they would describe, they create as well as measure attitudes, they elicit atypical roles and responses, they are limited to those who are accessible and will cooperate, and the responses obtained are produced in part by dimensions of individual differences irrelevant to the topic at hand. (p. 1)

Development of the curriculum documents had been lived forwards, whereas interviews would be more likely to pick up a more recently developed understanding. As Suchman argues,

> Stated in advance, plans are necessarily vague, insofar as they must accommodate the unforeseeable contingencies of particular situations.
>
> Reconstructed in retrospect, plans systematically filter out precisely the particularity of detail that characterizes situated actions, in favor of those aspects of the actions that can be seen to accord with the plan. (Suchman, 1987, p. ix)

It seems likely that interviews would have picked up the retrospective construction--interesting in itself, but a rather different project.

It seemed that, if interpreted within context, the documents themselves would present an appropriate research base, particularly if supplemented by other relevant published material. They did, after all, represent deliberate choices made at the time and were an "unobtrusive measure" (Webb et al., 1966).

I had also thought to use later documents (1987-1989) as a base for comparison, but these are, as yet, very incomplete, a number of institutions delaying their preparation by seeking extension of accreditation because of extensive institutional amalgamations in NSW, as elsewhere in Australia. I have marginally drawn on more recent available documents, but have centered on the 1984 documents.

Since the documents are reasonably public ones (and are historical documents), I chose not to mask them in some pseudoanonymity which would be fairly easy to penetrate. Although originally private to the institution concerned and the accrediting authorities, they can now be considered to have passed into the public arena, a collection of them being available in the NSW College of Nursing library. They also appear, in abbreviated form, in institutional handbooks and flyers. I have not, however, identified people by name, as this seemed unnecessary.

Doing research and its reporting is, as Richardson argues, a site of moral responsibility which goes beyond issues of "informed consent" which the use of reasonably public material does not seem to involve. In the context of discussing interviews, Krieger writes,

> Sometimes in social research when interviewing is discussed, it is as if confidentiality was a matter of explicitly imposing moral principle and control ... but it seems to me worth noting that part of what make interviews work is more elusive, and dependent in an unsaid way on some mutually shared belief in the benignness of the processes of a larger world. It is also dependent on permission, but that may be implicit and rules for regulating implicit processes are different.... They are not legal and they are not formal. They depend on trust--and persons trusted may not know the difference it makes until the trust in them fails. (Krieger, 1979, p. 172)

Although I did not conduct formal interviews, I clearly remained part of the world I was researching. My colleagues were aware of the nature of my doctoral dissertation but continued to talk frankly with me. They were happy to make available any information I requested, occasionally specifying where they would prefer draft material not to be quoted. The mutual trust thus exhibited creates a need for "skilled ethical comportment" (Benner, forthcoming) which, I trust, I have managed to achieve. As Krieger points out, this has an importance that goes far beyond formal rules or legal requirements.

The material presented here can be largely understood as an attempt at temporal articulation. The broad articulation begins with an understanding of nursing's origins and its attempts to develop its knowledge base (chapters II-IV). It then considers the connections between nursing knowledge and curriculum in development in the USA in a way that connects with the Australian and NSW background. Having established an understanding of this background, the study then focuses on the guidelines issued to institutions and then on the documents themselves. The final chapter looks at some of the

possibilities that open up.

In dealing with both the guidelines and curriculum documents, I have endeavoured to interpret them in the light of my situated understanding, which includes the understanding developed from the literature (detailed in chapters II-IV). I have concentrated on the philosophical statements and the conceptual frameworks, with a more general reading of course statements to gain an impression of the consistency with which the ideas were worked through and the overall content. Since material covered under "philosophy of nursing" in some documents was covered under "conceptual framework" in other documents, I have read them as one, treating them as a unified attempt to explicate the knowledge base.

Having gained an overall sense of the frameworks, I selected out what appeared to be key words and phrases, but in developing interpretations, returned repeatedly to the documents to ensure that these interpretations meshed with context. This process frequently resulted in revision of the interpretation, since the meaning of key words and phrases is highly context-dependent.

Any generalization at all involves some degree of simplification of very complex phenomena, but we are inevitably involved in such generalizations as we endeavour to make sense of the world in our reflective mode. There is a need to test such generalizations as rigorously as possible, but the particular will always, to some extent, escape the general. There is also no way we can gain a transcendent position from which to view the phenomena to imbue such generalizations with certainty--we remain situated beings.

> The hermeneutic method aims at a progressive uncovering and explication (which is, of course, never fully completed) of the researcher's practical understanding of what is being studied. This in turn involves becoming more aware of some of the interests, habits and practices that form the background against which the phenomena appear and take form. (Packer, 1985, p. 1089) (emphasis added)

To the extent that such practical understanding takes the form of generalization, it is a legitimate part of the process, but needs to be treated with considerable caution because of its tendency to cover over. In Heidegger's terms, any new angles of light must also contain concealment.

Having been as careful as possible with the development of interpretation, the question of its presentation arises (although it actually arose throughout, not as an end-stage determination). As Richardson (1988) points out, narrative is a primary means by which we make the world intelligible, and is contained in even the most abstruse scientific writing (which also contains such rhetorical devices as image and metaphor). These affect how ideas are formed, notes taken, questions phrased, as well as how the work is written up and understood by its readers.

My guiding metaphor fits within the liberation narrative she outlines, that is, I have taken the aspirations of nursing as legitimate, although not always agreeing with the tactics adopted. The overall thrust is toward empowerment by the opening up of possibility. Indeed, it is clear that I see the liberation of nursing knowledge as part of the wider struggle for the recognition of knowledge embedded in the female world, which is in turn part of the

feminist agenda.

Richardson describes the liberation narrative as follows:

> This narrative tells the story of the disempowered, not by judging, blaming or advising them, but by placing their lives within the context of larger social and historical forces, and by directing energy toward changing those social structures which perpetuate injustice. (Richardson, 1988, p. 204)

My own situated position as a nurse is thus analogous to that of the woman, the black, the indian, or the aborigine who seeks to develop such an empowering narrative (of which there are now a host of examples).

In keeping with the recognition that use of the passive voice creates an illusion of objectivity--implying the presence of a transcendant, god-like narrator (Richardson, 1988, p. 203), I have adopted the active voice--the speaking "I"--where appropriate. This has the added advantage of greater intelligibility because it avoids the awkward, convoluted constructions often necessary to achieve the passive voice. The alternative of using "one," while sometimes appropriate, particularly for whimsy, has the similar effect of distancing narrator from narrative. But it, at least, is a somwhat more transparent rhetorical device. As with all rhetorical devices, one needs to "ring the changes" to avoid inducing tedium in the reader. The "I" construction used to excess can become overwhelming.

In truth, it is not possible to clearly distinguish between the planning of a research proejct, its carrying out and its narration, because they are inextricably intertwined. Any account of methodology is therefore an ex post facto construction, usually aimed at making

the process appear a linear one. I have been unable to avoid the temptation of the linear approach, although I recognize it as a reconstruction of a very complex process along the lines suggested by Suchman (cited above), and would like to acknowledge this to you, the reader.

The Data

The major source of data for this study is the NSW curriculum documents produced between 1983 and 1988 (inclusive). The majority of the documents were produced in 1984, prior to the state-wide movement of nursing education out of the hospital schools of nursing into educational institutions which commenced in 1985 and was completed in 1987.

The Illawarra Regional Council of Nursing in conjunction with the Institute of Education, University of Wollongong had developed a curriculum in 1983 in preparation for the change-over. It was introduced in 1985 with some modifications to fit the subsequently developed guidelines, and this modified course (now under the sole aegis of the University of Wollongong) was published in 1986.

Armidale College of Advanced Education was denied accreditation on its first document, and produced another before the end of 1984 with second and third year courses not detailed, to allow the college to be permitted to take a 1985 intake. The full documentation was produced in 1985 and subjected to a full accreditation process. As it was given accreditation for only 3 years (instead of the normal 5 years), a further curriculum document was produced in 1987, gaining

the normal 5 year accreditation. There are thus four curriculum documents from Armidale, although the third is the more detailed form of the second, so I have excluded the second.

Northern Rivers College of Advanced Education were unsatisfied with their document, which had undergone substantial revision. The appointment of a new Head of School prompted a decision to prepare a new document for early accreditation in 1988 and this was included in the study.

The names of some of the institutions have changed since the documents were written, but I have identified them by the name in use at the time of the document. There seems little purpose in identifying these brief changes of name, as all institutions are now in the process of forming universities or becoming part of existing ones, in accord with government policy. All the names at the time of the preparation of the documents either have disappeared or are disappearing, with the possible exception of Avondale College of Advanced Education, a private Seventh Day Adventist institution. The institutions and the abbreviation for their documents are listed below.

NSW Institutions Originating Documents	Document Identification
Armidale College of Advanced Education	ACAE 1984 ACAE 1985 ACAE 1987
Avondale College of Advanced Education	Av. CAE 1984
Catholic College of Advanced Education	CCAE 1984

NSW Institutions Originating Documents	Document Identification
Cumberland College of Health Sciences	CCHS 1984
Hawkesbury Agricultural College	HAC 1984
Kuring-gai College of Advanced Education	KCAE 198
Macarthur Institute of Higher Education	MIHE 1984
Mitchell College of Advanced Education	CMAE 1984
Nepean College of Advanced Education	Nep CAE 1984
NSW Institute of Technology	NSWIT 1984
Newcastle College of Advanced Education	NCAE 1984
Northern Rivers College of Advanced Education	NRCAE 1984 NRCAE 1988
Riverina College of Advanced Education	RCAE 1984
Sydney College of Advanced Education	SCAE 1984
Illawarra Regional Council of Nurse Education in conjunction with Institute of Advanced Education, University of Wollongong	U of W 1983
Institute of Advanced Education University of Wollongong	U of W 1986

There were thus a total of 19 documents (or 20 if the second 1984 document from Armidale were included).

Background Documents

The curriculum documents are interpreted against the background of guidelines issued to institutions. The most significant of these were those issued by the NSW Nurses Registration Board and the NSW Higher Education Board because they had mandatory significance. (An

account of the role of these bodies can be found in Chapter VII and an analysis of the guidelines in Chapter IX.)

The names of these documents and their identification in the study is as follows:

NSW Higher Education Board--Basic Nurse Education: Guidelines for Advanced Education Institutions in the Preparation of Documents--March 1984 (abbreviated to HEB 1984).

NSW Nurses Registration Board--Basic Nursing Education--undated, but early 1984 (abbreviated to NRB 1984).

The State Planning Group for the transfer (explained in Chapter VII) issued bulletins to keep institutions in touch with developments and provide ongoing advice, largely of a logistical nature. These are less significant for this study, but, where used, are abbreviated to SPG, Bulletin Number and date.

For purposes of comparison with the pre-existing situation, I have also used the 1976 Nurses Registration Board syllabus.

I have also drawn on available material in the form of reports of accreditation committees and correspondence where useful to illustrate particular points. My access to these is most complete in the case of my own employing institution, and it is largely in this context I have used them in order to develop an understanding of the situation in which Armidale College found itself, as the only institution which was initially denied accreditation.

Situated Background

In developing my interpretation of the guidelines and documents, I have drawn on understandings built up through contact with colleagues during the change-over process. The official forum for such exchanges was the NSW Nurse Academic Forum which met two or three times a year. But there was also considerable informal contact, usually by telephone, or in the face-to-face situation, at conferences and meetings organized for different purposes. At my own institution, I occupied the position of Chairperson of the Board of Nursing Studies from September 1984 (on my return to the USA), later moving to the position of Head of the Centre for Nursing Studies (September 1986) on the resignation of the previous Head. I was also the institutional representative on an Australia-wide committee looking at ways to rationalize external studies in nursing (which was directed at the RN market). Despite its focus on the RN, this committee inevitably discussed basic preparation programs as well with which the RN programs had to articulate. Thus, although I focus on the NSW documents, my understanding was also developed against a less specific Australia-wide background. (This committee also met two or three times a year.)

I have used little specific material from this background, yet it is present in a general way. Where I have used specific material, I have included the necessary details without identifying individuals by name, in accord with reasonable ethical comportment. In the one instance where I was concerned about possible ramifications of an individual being identifiable, although not identified by name, I

checked with her and she could see no problem.

Method

Step I

I originally read the documents through to get an overall sense of them as a whole. The impression gained at this stage was that few documents exhibited consistency of framework and that documents exhibited considerable similarity at the level of course content whatever the framework they adopted. There were differences in ordering of material and some slight differences in content, more marked in the area of support subjects.

Step II

I went through the documents in more detail, looking particularly at the statements of philosophy and conceptual frameworks, which proved impossible to clearly distinguish. The reason was that what some institutions included under philosophy, others included under conceptual framework, and vice-versa. I therefore decided to treat them as one, as laying out the conceptual ideas that organized the curriculum.

At this stage, I underlined key words and phrases and made marginal notes, but remained very confused.

Step III

I went to the guidelines documents, prompted by Tanner, Diekelmann, and Allen's (1988) critique of NLN guidelines. I had previously read but backgrounded these, experiencing them as part of the curriculum development process but not reflecting on them as a way

of understanding the curriculum documents, their production and accreditation. Reflecting on them was an illuminative process, the results of which are reported in Chapter IX.

Step IV

Coming back to the curriculum documents, I summarized their organizing frameworks, putting together the gist of what was being said, the central thrust, the ideas that seemed most important to the framers of the documents. The general overview material in the documents (philosophy, conceptual framework, aims and objectives) were read and re-read until I was satisfied that I had a reasonable grasp of the central ideas. The curriculum documents were then grouped and discussed as groups. Despite my best efforts, I could not get the groupings below seven without covering over differences which seemed to be significant and which illustrated important aspects of the process by which nursing knowledge was being re-formed. This discussion can be found in Chapter X.

Step V

Since most curriculum documents contained some discussion of aspects of the "metaparadigm"--human beings, environment, health, and nursing--whether explicitly identified this way or not, I listed the terms used under each of these headings. (A summary of my listing can be found in Appendix A.) I then grouped and discussed this material, again checking back with documents to endeavour to ensure contextual understanding. The results of this process are in Chapter XI.

Even setting it out in this way oversimplifies a very complex process of moving back and forth among the documents and between the

documents and my notes and emerging understanding. I had hoped that 1989 documents would be available for comparison, but at the time I left Australia (in July 1989) they were either still in process or had been delayed because of funding amalgamations or appointment of a chair in nursing (as in the case of University of Wollongong). Some institutions had been re-accredited, but documents were not yet generally available. Some colleges sent draft material, stipulating that it not be cited.

From the telephone discussions I had with senior staff at the institutions, envisaged changes seem to be generally in the direction of further development of existing approaches. As I point out in Chapter X, this can even be seen in the cases of Armidale and Northern Rivers College who extensively re-developed their documents, yet retained continuity with their earlier approaches.

CHAPTER IX

THE NSW GUIDELINES FOR CURRICULUM DEVELOPMENT

Two main connected themes appear repeatedly in the U.S. nursing curriculum literature during the 1970s--integration and conceptual framework. Both terms have a variety of meanings, different writers often using them in different and often ambiguous ways.

There are at least five possible meanings of integration:

1. Integration of theory and practice.
2. Integration of the concepts of other disciplines into nursing.
3. Integration of the nursing and support subjects.
4. Integration of the nursing major by the use of organizing concepts across specialty divisions.
5. Obliteration of the specialty divisions themselves by focusing on "generalist" concepts.

Examination of the guideline documents for NSW shows that both sets of guidelines (from the NSW Nurses Registration Board and NSW Higher Education Board) show a requirement for the first, although the NRB document refers to correlation rather than integration--"correlated practical experiences" (NRB, 1984, p. 2), implying a less tight connection. However, the HEB document states,

> Theoretical studies and clinical practice require close integration; this should be built in at the course-design stage so that the concepts which the practice seeks to teach can be acquired in a range of settings. (HEB, 1984, p. 1)

Of note is the recognition that practice can teach, as Diekelmann

argues, although the same assumption of unproblematical transfer between classroom and clinical arena seems to be operating as she criticizes. The last sentence also suggests integration in the fourth and possibly fifth sense above. Since specialty areas are listed for essential instruction and highly desirable experience, the fourth seems more likely. But the guidelines go on to say,

> The listing of these areas does not imply that they must necessarily be taught as discrete units. Institutions will determine their own ways of integrating these areas into their preferred curriculum model. (HEB, 1984, p. 2)

So that it may be that a choice between four and five is being offered.

The HEB guidelines are ambiguous with regard to "support subjects," on the one hand requiring that they be "designed so as to emphasize those facets of traditional disciplines which have a bearing on the practice of nursing" (HEB, 1984, p. 2), and on the other, suggesting the "sharing of some learning experiences with students from other disciplines" in the areas of "Biological, Physical, Social and Behavioral Science" which are seen as the "support subjects." The latter suggests the use of service courses--courses already being taught in the institution to other students, the use of which would tend to make the former harder to achieve, except where the institution had a health science focus (really only true of Cumberland College of Health Sciences, although partially true of Newcastle College of Advanced Education).

The writers of these guidelines appear to be torn between two ideologies--between wanting everything to focus on and be relevant to

nursing and wanting nursing students to be introduced to the "traditional disciplines" with other students and thus become more integrated into the mainstream of the institution. In many institutions, there were just no suitable service courses to meet this sort of ambiguous requirement. Where institutions did use service courses, logistic problems arose because of the difficulty of scheduling around nursing students' clinical placements.

Apart from this very real logistic problem, available course evaluations demonstrate the difficulties of using such service courses in relation to the first requirement. Students experienced difficulty in relating material to nursing and some institutions sought to overcome this by tutorials conducted by nurses that helped the students understand the relevance of the "traditional disciplines" to the nursing major.

There are at least four senses of the term Conceptual Framework in the U.S. literature:

1. A conceptual framework for the whole curriculum, comprising subject, student and setting (Chater, (1975).
2. A conceptual framework for the knowledge (subject) component of the curriculum.
3. A conceptual framework for the nursing knowledge component.
4. Use of a "conceptual model" or theory of nursing as an organizing framework for nursing knowledge.

The first and second are relatively rare in the literature and the third and fourth tend to blur and become confused. This blurring I have related to the ideological thrust of the demands for a

"conceptual framework."

The HEB guidelines recommend the second and possibly the third. Although institutions were required to state their "teaching-learning philosophy" and details of the setting, these tended not to be seen as part of the conceptual framework which was seen as developing out of "a philosophy of Nursing" (HEB, 1984, p. 1). The sequence of steps suggested, although psychologically impossible, are instructive.

The following planning sequence is recomnended to institutions:

> (a) determination of a philosophy of Nursing;
> (b) construction of a model for the Nursing curriculum;
> (c) planning of the major sequence in Nursing, including the clinical experience component; and
> (d) planning of supporting studies in such a way which integrates them with the Nursing major.
> (HEB, 1984, pp. 1-2)

In requirement (d), integration is being used in the third sense, viz integration of nursing and "support subjects," although the word does not appear where the "support subjects" are dealt with in detail, as previously discussed.

The recommended sequence suggests a preoccupation with the shaping of nursing knowledge, similar to that in the U.S. literature. The assumption is being made that what is good for the development of the discipline is also what is good for introducing students to nursing, although this is never spelled out in so many words. As Welch and Slagle (1980), in a rare critical piece of U.S. literature point out, one cannot simply assume that approach helpful to faculty in integrating nursing content will necessarily be the approach useful to the neophyte, because faculty come to the integration experience

already possessing a broad background in the area.

The ambiguities of the guidelines made it difficult for accrediting committees to decide whether a proposed course met them. I will illustrate this with the example of the College by which I was employed (Armidale College of Advanced Education) for two reasons. Firstly, it received the harshest assessment and was the only one granted less than the normal five year accreditation (three years, and only that after considerable re-writing). Secondly, complete documentation is available.

I was not involved in the first preparation of this curriculum document, as I was overseas. However, I was associated with its written defense in reply to the report of the accreditation committee after my return (September 1984) and later chaired the committee which re-wrote the submission (the previous chair having declared herself to be suffering from "curriculum burnout"). I also chaired the committee which re-wrote the curriculum for re-accreditation in 1987, which was gained without problems for the normal five years.

As I had worked for this institution since 1975, I was very much a situated participant (see Chapter VIII), and the reader needs to be aware of this. Being situated has some advantages in providing access to meaning and interpretation beyond what appears on the printed page, to which an accrediting committee of "outsiders" has less access. By this I mean that when I read the original document, in a sense, I read a different document to that which the accreditation committee read, because of my immersion in the meanings that college faculty had come to share. Too little of this was spelled out in the document,

particularly with regard to the reasoning behind rejection of certain popular approaches. However, involvement also raises the spectre of "bias" and it is only fair to state one's position and allow the reader to judge.

The initial assessment of the curriculum document prepared by this institution illustrates, I believe, the difficulties posed for committees by the ambiguities of the guidelines. In this report, they stated that,

> The Nursing Studies component could be developed to reflect a coherent philosophy and a more logical content, based on the identification of patient needs and problems. Clinical experience could then be directly integrated with the nursing core. (ACAE Committee Report, 1984, p. 1)

From the above, this committee was looking for integration in the first and fourth sense viz integration of theory and practice and integration of the nursing major by the use of organizing concepts. However, at the same time, the committee also suggested,

> A greater integration of course elements, involving a development of the Behavioural and Biological Sciences components to reflect a closer conceptual and temporal integration with Nursing Studies, in sequencing and teaching (Committee Report ACAE, 1984, p. 1)

thus demonstrating a further interpretation of integration as in the third sense--integration of nursing and support subjects.

In its response to the Committee, the College took the stand that it was not pursuing integration as a major goal because of the danger of creating a "nursing ghetto" within the College sector (since excessive integration creates courses which only nurses can teach). The response goes on.

> In the context of the proposed curriculum, "integration" is seen as an appropriate term for describing the links between the nursing course and their related clinical experience, but the term "articulation" or "interrelation" is preferred to describe links between the courses in the related disciplines and the nursing major. Such articulation is both horizontal and vertical.
>
> The statement of philosophy of nursing (p. 13) specifically states the intention to develop "... the student's ability to integrate ideas and concepts into practice." Such an endeavor is hampered by excessive spoon-feeding (a common criticism of the current hospital programs). Within this context, spoon-feeding may be seen as making all the links for the students, rather than encouraging them to make their own linkages.
>
> If students are to learn to integrate, they must have material on which to practice. This is achieved by presenting material concurrently and sequentially in order to encourage the students' own integration. (Letter, Principal ACAE to Chair of Accreditation Committee, September 1984, p. 2)

Apart from the self-righteous tone of the letter, the College introduces into the debate a sixth sense of integration--integration as student activity--which is relatively absent from the nursing literature. However, in 1976, Styles did raise this cogent issue.

> [C]ould we agree that a fundamental intent of education is to assist the learner to achieve integration--that is, to discern and use relationships among the knowledge, skills and values learned--to perceive a field as having a wholeness or unity? (Styles, 1976, p. 739)

Apparently, we could not so agree, as integration continued largely to be dealt with in terms of a faculty-imposed phenomenon, although Welch and Slagle also picked up the issue in 1980, as discussed above, in an article appropriately titled, "Does Integrated Content Lead to Integrated Knowledge?"

In terms of the view of knowledge as web discussed earlier, this approach could be seen as facilitating the students' own ability to weave, rather than covering the students with a web of the faculty's weaving. This type of thinking meshes well with the current U.S. "curriculum revolution" thinking which endeavours to shift the emphasis more toward the students and their empowerment through knowledge, away from the top-down hierarchical (faculty-centered) approach. Within the broadest meaning of conceptual framework (Chater, 1975), this approach shifts the balance back toward with student and setting, away from the overwhelming emphasis on content (subject) which informs most of the literature.

Without denying some elements of ex post facto rationalization, this defense was coherent with the general approach the College tended to adopt--that is, with its background meanings (which had been inadequately addressed in the documents, simply because they were part of the taken-for-granted, tacit understandings).

Although in a report to another College (Northern Rivers College of Advanced Education), their committee stated,

> Curriculum parameters set down in HEB and NEB publications were intended only to serve as guidelines and were open to modification by institutions where it was believed that there was educational justification for doing so. (NRCAE Report, 1984)

the committee accrediting the Armidale CAE course showed no willingness to "buy" this student-centered view of integration, even when it was spelled out more explicitly than in the original document. It is interesting to contemplate how they would have reacted to

Diekelmann's (1988) arguments against even the integration of theory and practice (which the Armidale response had accepted).

The Armidale defense also adressed and defended in more detail its organizing framework, also spelled out largely in terms of student development, coherent with the institutional approach. This also fell on deaf ears, the committee iterating its advice to use patient needs and problems as a framework, although Armidale's response had explicitly rejected philosophically such an approach (in distinction to the original document which did not explicitly address the issue). From this, it was clear that the Armidale accreditation committee at least was looking for at least a conceptual framework in the third sense, viz a conceptual framework for the nursing knowledge component.

The Northern Rivers committee believed that college had taken the guidelines too literally, Armidale was criticized for not taking them literally enough, and, between these extremes the confusion was reflected across the state. Although Armidale's program was the most strongly criticized (for many complex reasons, not all of them educational), its position was by no means unique. Discussions in the latter part of 1984 with colleagues from other institutions revealed a considerable degree of disquiet and anger about accreditation committees among senior nurse academics. In general, the situation was understood in terms of committees looking to see some ideal nursing curriculum, which they were not able to specify but which they would be able to recognize if they saw. In some quarters, the response to what was perceived as excessive prescriptiveness was, "Why don't they just give us a syllabus and tell us to teach it?"

But it is possible to take a more sympathetic view of the committees' position. Given the ambiguities of the documents, it was little wonder that different readings were made "between the lines." In turn, a key to understanding the emphases and ambiguities lies in the emphases and ambiguities of the U.S. literature from which the ideas were being generated. As with the NLN guidelines, curriculum was being seen as a lever to shift the nursing knowledge base, more than as an activity to move students from neophytes to beginning practitioners. I suspect there was also some ambition to outdo the Americans in this endeavour, as we were outdoing them in total system transfer.

Such an expectation, to the extent it existed, was patently unrealistic, given the speed with which curriculum documents had to be put together and the lack of an appropriate experiential background on which to draw.

Within the perspective I have described which sees some common nursing phrases as metaphors, the problems arising between accreditation committees and institutions can also be understood as confusions between metaphoric and literal understanding arising both ways. Thus some colleges were criticized, as was Northern Rivers, for taking the guidelines too literally, which was probably not unrelated to its position of distance from the metropolitan area of Sydney where the greater opportunity for dialogue built up the acceptable set of interpretations. Armidale was similarly isolated and built up its own idiosyncratic set of interpretations, less accessible to a committee who had largely been engaged in the Sydney dialogue.

On the other hand, many colleges were criticized for dislocation between their philosophy, conceptual framework, and aims and objectives. As I have argued, the translation of nursing metaphors into literal language leads to the banality of lengthening nursing histories, nursing diagnoses lists, and standardized "treatments"--a species of banal reductionism. Nursing metaphors are highly likely to occur in statements of philosophy and, to a lesser extent, in conceptual frameworks. As metaphors, they are important in providing a vision of the enterprise, the flavor that permeates the program. But their simple translation into the language of objectives involves the same sort of banal reductionism.

It is possible to pick up objectives (as the Armidale CAE response did) and show in a broad and general way how they relate to the philosophy, but the Tylerian model of simple translation from philosophy to aims to behavioural objectives to evaluation in terms of objectives is extremely reductive. To be fair, committees did not use this extreme degree of reductionism, but to the degree they were influenced by the Tylerian model, all courses were open to criticism on this point.

The 1984 curriculum documents were drawn up rapidly under less than ideal conditions in most institutions. A nurse was appointed as a senior member of staff in institutions not previously involved in any way in nursing. In nine institutions, the document was primarily the work of this one person, in consultation with local senior members of the profession, the Nurses Registration Board, the Nurses Education Board, and non-nurse academics of the institution. Despite this

consultation, it is reasonable to say that the curriculum document as largely the work of and reflected the thinking of one senior (recently appointed) nurse academic.

Six institutions had some already established nursing faculty and three of them (Cumberland, Riverina, and Avondale) were already involved in pilot programs in basic nursing preparation. The remaining three (Armidale, Newcastle, and Sydney) were involved in courses for registered nurses in education and administration. In these institutions, there was a larger thought-pool on which to draw, but concomitantly more potential for conflict. Two of the senior academics appointed to institutions new to nursing had previously headed nursing in institutions already involved. In these cases, the curricula demonstrate close simlarities and can usefully be regarded as pairs. But, on the whole, institutions confronted a new set of problems as they were required to develop speedily for a February 1985 intake. Even institutions with pilot programs had to redevelop their programs to conform with single register requirements and /or increased student numbers.

The Pre-1985 System

The pre-existing system was one tightly controlled by the NSW Nurses Registration Board who set the syllabus requirements, both theoretical and experiential, inspected hospital training schools and set the registration examination. Although in the years leading up to 1985, the syllabus had been re-titled "Guidelines for the Curriculum" and "nurse inspectors" had been re-titled "nurse advisors," nurse

teachers generally continued to interpret the guidelines as a syllabus and to see nurse advisors in an inspectorial role. (This generalization is based on discussions with nurse teachers over eight years of coordinating a program in nursing education.) It was easier not to bury arguments with the Registration Board, but to tick off lectures as having been given and rotations as having been completed.

The Registration Board examinations, particularly, although not exclusively, in general nursing, had been moved to a multiple-choice format which encouraged the teaching, memorizing, and regurgitation of "facts". Hospital schools tended to shape their teaching and assessment the same way in order to prepare students for "The Finals"--the examination that really mattered, because it was for registration. Students in the pilot programs in higher education also had to sit "the Finals," which thus shaped their curricula.

The 1976 "Guide for the Syllabus of Subjects for the Practice of Nursing for General Student Nurses" which accompanied the curriculum guidelines for implementing the 1000 hour curriculum still shaped nursing very much along the lines of medical specialties with nursing added, although symptoms of the "additive curriculum" were also present. Of the 1000 hours, 426 were taken up with medical specialty topics with nursing practice attached, and the practice of using doctors to teach these areas continued as a possibility although it was no longer mandatory. This contrasted with 100 hours for the practice of nursing, although, to be fair, more specialized nursing practice could be built in under other headings. Other areas of the curriculum followed hospital geography--operating theatre, recovery

room, accident and emergency and rehabilitation.

When allowance is made for more than 200 hours in the basic sciences and behavioural sciences, the picture of the conceptualization of nursing knowledge that emerges is one supportive to the medical specialties and the geography of the hospital, which was consonant with the rotation of a paid student workforce through the wards and units of their employing hospital.

In the light of this background, it is perhaps more surprising that College curricula moved as far as they did, rather than that they retained, to varying degrees, elements of the legacy of the hospital-based system. But such surprise would only be possible if one ignored the momentum for change that had been building up. Nurse teachers had become better educated and more aware of the nursing literature and were increasingly impatient with the constraints of the old system. But this very momentum probably gave rise to unrealistically high expectations.

The NSW Nurses Registration Board, like other state registering authorities, had shown its readiness to consider change within the hospital-based program in its 1976 guidelines for the implementation of the 1000 hour curriculum, but was hampered by its past legacy and the format of its Finals. In retrospect also, its guidelines at that point, can be seen to have been too much like the traditional syllabus to stimulate the imagination of nurse teachers generally, although the pilot college programs received approval.

The set of guidelines issued to education institutions in early 1984 were very different, being spelled out mainly in terms of the

competences expected of graduates. Although the guidelines retained the right of the NRB to have graduates sit a registration examination, the intent was to bring nursing in line with other professions in Australia where successful completion of an approved course of study ensures professional registration. In the event, this is what happened, although institutions were left dangling for more than a year and were required to submit one lot of detailed course outlines and assessment materials to the NRB before it declared its intention to register all those who satisfied institutional requirements for the award of the diploma.

The 1984 NRB Guidelines

The guidelines issued in March 1984 were drawn up in consultation with members of the profession in a series of workshops. They listed the following seven groupings of competences for beginning practitioners.

1. Assessment
2. Planning and Intervention
3. Safety
4. Health Promotion
5. Habilitation/Rehabilitation
6. Communication and Interpersonal Skills
7. Management of Professional Practice

Three to five broad behavioural objectives were developed under each of these headings, but the content and its sequencing to achieve the competencies were left to the institutions to determine. However, in

its listing of points drawn to the attention of colleges that preceded the list of competencies, point 11 reads,

> 11. The curriculum should be concerned with all aspects of care according to age, disability, socio-cultural background, setting and environment and provide for consultation with the individual, family and group. Nurses would be expected to gain competence in assessing their own delivery of care. The course shall include studies in behavioural and biological sciences. (NSW NEB, 1984, p. 2)

This can be read in conjunction with their first statement under the heading "The Board's philosophy is that",

> 1) A basic nursing program shall provide a broad and sound foundation for medical and surgical nursing, psychiatric nursing, maternal and child health nursing, paediatric nursing, nursing care of the aged and of the developmentally disabled in a variety of institutional and community settings. (NSW NEB, 1984, p. 1)

The universalism of point 11 certainly needed interpretation, although, strangely enough, they omitted gender as a variable! In a sense, the interpretation is supplied by the "philosophy" statement, indicating the need to placate all interest groups in the move to a single register. A similar listing of specialty areas occurs in the HEB guidelines under the heading "areas in which instruction is considered essential and experience desirable" (HEB, 1984, p. 2). A caveat, similar to the one in the 1976 NRB guidelines, however, is added,

> The listing of these areas does not imply that they must necessarily be taught as discrete units. Institutions will determine their own ways of integrating these areas into their preferred curriculum models. (HEB, 1984, p. 2)

Given the past history detailed above, the temptation was to teach them as discrete units, as this was the easiest way of demonstrating coverage of them. Not everybody was able to resist this temptation, yet, in the interpretations made, the expectation was clearly that of the second sentence--some integrating framework was expected that would remove the discreteness of the specialty areas.

In both point 11 and the HEB documents, the areas in which support for the nursing major should be sought were specified, although in slightly different terms in the latter--the "Biological, Physical, Social and Behavioural Sciences" (p. 2). While this is very broad and may seem like common sense (one therefore wonders why it needed stating), such a listing tended to block imaginative reflection across the full range of possible support subjects, including the arts and humanities. On the whole, most curricula selected a very similar range of support subjects with an uncanny resemblance to those in the pre-existing NRB curriculum.

It is possible to conceive of other areas of study which could be seen as supportive to the nursing major and such an approach, if argued, may have been accepted. The point is, however, that, by stating the obvious the obvious became even more obvious, fore-shortening the process of reflection. This was reinforced by the HEB guidelines going on to suggest that nursing students should also be given the opportunity to take "Liberal and General Studies courses available to their fellow students."

> Such studies have the potential to enhance personal development and enable Nursing students to participate in the wider life of the academic

> institution. However, the opportunity given to students to undertake Liberal and General Studies should not alter the main emphasis of the course, which is Nursing and related studies. (HEB, 1984, p. 3)

Liberal and General Studies were thus seen as distinct from "related studies," the areas of which had previously been listed. The similarity, within the broad areas laid out above, of even the areas of the support subjects chosen, may have been inevitable, given previous history. Yet it is also obvious that the guidelines did not encourage a more lateral thinking approach which, by considering more broadly possible related studies, may itself have interacted with the process of shaping the nursing major. The guidelines also provided encouragement within the institutions, for the empire-builders from "related disciplines."

The guidelines were thus ambiguous in wanting something new and yet reinforcing the legacy of the past. This could be understood in terms of the conflict between wanting to re-make nursing and distrusting the relatively unknown higher education institutions to "do the right thing" by nursing. There seemed to be a fear that nursing would be re-made utterly unlike itself, but, at the same time, a hope that it would be re-made considerably. A reasonable judgment, on the basis of the documents is that neither the fear nor the hope eventuated.

Casting the net wider for "related discipines" might, in any case, have been a risky thing to do. One appointed Head of School who was writing a curriculum document for an institution not previously involved in nursing was asked by intending students for a reading list

which they could read in preparation. She prepared a list of quality literature in which the experience of illness/ dysfunction and/or the nurse was portrayed. The list came to the attention of senior members of the profession who interpreted it as a textbook list and were suitably horrified. Without consultation with her, they went to the regional nursing officer, demanding that she "be stopped." Even when she was allowed to explain, her explanation did not go down well and the aftermath continued to dog the institution in organizing clinical placements.

Yet virtually all curricula espoused "holism," and the biological and behavioural sciences are reductive. The most "holistic" accounts of illness as experience are probably to be found in literature (which is not to exclude the other arts). The curriculum of this institution adopted a strong "lived experience" focus--the only one to really do so.

Although it is commonplace to talk about the art and science of nursing, art is usually treated as residual category for what cannot be fitted under science. Thus, the place of the sciences in nursing curricula is conventionally established as providing the basis of nursing/medical science, but the art is seen as something caught rather than taught, and rarely seen as grounded in "the arts" which did not have an established place in traditional nursing curricula, as the sciences did. The guidelines reflect this traditional view--arts are for personal, not professional, development--they are an extra.

The reading list issued by this Head of School appeared to violate these conventional boundaries, which can perhaps be best

understood in terms of the continuing dominance of the medical model, despite its overt rejection. Medical curricula ground themselves in the sciences and the watered-down version of the medical curriculum traditionally taught to nurses did likewise. Thus, the encouragement of nursing students to take "liberal and general studies" for personal development had its precedent in similar moves in medical curricula in Australia--token gestures toward the development of a more "rounded" person.

The reading list, understood as a textbook list, thus violated the boundaries which have traditionally separated nursing, like medicine, from "the arts." What seemed to be feared was that the course being developed would ground itself in a very unconventional way. I hesitate to report rumours, but in this case it seems appropriate. Even in its final form, a senior member of the profession was reported to have said of this curriculum that she was sure it would produce a very good human being, but was doubtful whether it would produce a good nurse. However accurate or inaccurate its origin, its circulation (even quotation with a certain amount of glee) around NSW suggests the existence of tacit boundaries, the transgression of which was seen as putting the enterprise of producing "good nurses" at risk.

Since the original criticism came largely from directors of nursing, the concern was probably related to the graduates' ability to function in the service area, where "science" is the predominant (or at least most publicly acknowledged) mode. Within this context, a nursing curriculum with reasonably close alignment to traditional

medical curricula looks "natural," capable of producing a functional ("good") nurse. It is interesting to note that two other curricula (essentially written by the same person) which deviated from the mainstraim of the 1984 documents were philosophically close to an experimental medical curriculum that existed in NSW. Thus, medicine (or doctoring) continues to be a "destiny that shapes our ends, rough-hew them as we will."

CHAPTER X

NSW CURRICULUM FRAMEWORKS

Given that NSW institutions were required to construct a model for the Nursing curriculum (HEB, p. 1), what sort of models did they construct? I endeavoured to construct a table using Santora's 1980 criteria for comparison with her findings in the USA, but there was very little overlap with her categories, with most curricula falling into her ambiguous category.

Leaving Santora's categories behind as unduly constricting, I will endeavour to convey the central gist of the documents, grouping them as follows:

1. Humanities-informed
2. Problem-centered
3. Systems-based
4. Nursing process/Orem
5. Environmental/social
6. People/nursing
7. Health-illness continuum/health-illness trajectory

While it would be possible to group more tightly, differences which seem to be important would be lost. These groupings should therefore not be seen as definitive so much as heuristic, enabling some exploration of the varying directions taken by curriculum designers.

Humanities-Informed Curriculum

One curriculum (mentioned above in discussion of related studies versus liberal and general studies) made extensive use of the humanities, integrating them in fact into the core strand "Studies in the Discipline of Nursing." It was also the most philosophically sophisticated document in that it subjected its central concepts to detailed philosophical exploration, rather than simply asserting them. Thus, the central concepts of clinical relationship and clinical judgment are examined as is Orem's theory which forms the organizing framework for the Nursing core. Use of literature flows from a concern with "lived experience," "lived self," and with nursing as moral activity.

The clinical relationship is seen as imbalanced, the nurse's ability contrasting with the patient's disability, which is linked to Orem's idea of self-care deficits. It is this imbalanced relationship which generates the need for clinical judgment which is seen as centering around the questions,

> What can be wrong?
>
> What can be done?
>
> What should be done? (KCAE, 1984, p. 67 overleaf)

the last question drawing in the ethical component. Clinical judgment is thus seen as having both a scientific and an ethical component, not reducible to a conventional nursing-process or problem-solving approach, although a loose type of nursing diagnosis and possible interventions appear as part of the scientific component. The approach, in recognizing the problematical nature of the imbalance of

power in clinical relationship, is very close to the position adopted by Gadow (1988) who sees this imbalance (or vulnerability) as only redeemable by care. This document, in its conceptual framework, uses the terms trust, responsibility, compassion, and clinical judgment (which it sees as characteristic features of nursing) as the way the imbalance of the clinical relationship is redeemed.

While this may be an ideal view of nursing, it provides an organizing rationale for a curriculum aiming to produce this sort of nursing practitioner. The use of Orem (1981) links consistently with the desire not to erode the patient's freedom more than absolutely necessary, to minimize vulnerability and restore freedom as far as and as quickly as possible.

Problem-Centered Curricula

The curricula at two institutions, organized around patient problems, were basically the work of one person who had been on the staff of one institution and was then appointed to the other. This resulted in two very similar curricula, influenced by an experimental medical curriculum at a university adjacent to the first institution. This small and fairly recently established medical school had broken with tradition by centering its curriculum around patient problems rather than the more usual disciplinary orientation. Thus traditional areas, including the sciences, were covered throughout the program in reference to a series of patient problems. New materials had been developed to support this approach which aimed at producing medical practitioners whose interest was focused on patients rather than

medical science itself.

Similarly, these nursing curricula state, for example,

> The familiar labels given to blocks of knowledge ... do not appear as such in this document. However, the many aspects of content and skills related to such traditional organizing categories are reflected in the concepts explored within the selected problems to be considered within the health breakdown and life sciences strands and clinical practicums. A detailed examination of the supporting documents for each problem will confirm the extent to which one problem generates examination of many related concepts, skills and attitudes. (NCAE, p. 7)

The strands (vertical organizers) were--Health/Health Breakdown, Man/Woman, Society and the Intervention Process. Health Breakdown was chosen in preference to disease because "not all health problems the nurse encounters are disease process centered" (NCAE, p. 3). The vertical organization thus bears a close resemblance to what has been identified in the U.S. literature as the nursing "metaparadigm," although the specific connection is not drawn in the documents. Health breakdown is seen in terms of relative hindrance in performing the activities of daily living, which shapes the intervention process. Thus, there is an underlying assumption of a Henderson-type approach to nursing, indeed with the group who could be classed as deficit theorists (Henderson, 1960, 1966; Abdellah, 1960, 1969; Orem, 1970, 1980). This appears to link naturally with the adoption of a problem-centered approach.

Systems-Based Curricula

There were two systems-based curricula in two institutions, again linked by the movement of a senior nursing academic. While there are differences between them, they adopt an open systems approach, looking at stress and adaptation and seeing the process(es) of nursing as focused toward restoring equilibrium. While one institution does not really spell out its nursing theory base, the other endeavours to synthesize a range of very disparate theories (Watson, Henderson, Oralndo, King, Putt, Rogers, and Orem) to come to the school's position, but they are all interpreted within a systems/adaptation framework.

As the latter institution had been involved in basic nursing preparation for ten years and had an established faculty, the key to understanding this might be the statement,

> The School's model is eclectic in that it brings together concepts used by several theorists for their own distinctive constructs and links them in a way which gives expression to the views of all the faculty. (CCHS, p. 20)

Thus honor is satisfied without sacrificing framework coherence. The framework remains systems/adaptation, but the various theorists are drawn into the discussion of philosophical considerations influencing the curriculum and are taught as content.

Both curricula very deliberately articulate a process or processes of nursing, rather than "the nursing process," seeing it/them as communication, assessment, problem-solving, and decision-making. These form an organizing framework for the process strand of the Nursing major. (In one curriculum the vertical strands

are nature, focus, process, and practice of nursing and in the other nursing theory, nursing science, and nursing practice.) In both curricula, the nursing major is supported by studies in the physical, biological, and behavioural sciences, although these are only vaguely built into the conceptual framework which concentrates around the nursing major.

These are the only curricula that fit comfortably into Santora's (1980) classification and it may be significant that they had their origins in the educational institution which had been involved in teaching basic nursing preparation for ten years prior to the transfer (a pilot program). It would be easy to jump to the conclusion that experience led them to this choice of framework. However, since there is no evidence for the superiority of one framework over another, it seems more likely that their ideas had formed during the 1970s, drawing on the same body of literature that schools in the USA were using at that time. This could explain the ease with which they can be classified within Santora's framework.

Nursing Process/Orem Curricula

Seven colleges used the nursing process--assessment, nursing diagnosis, planning, implementation, and evaluation--as an organizer for the nursing major. Since nursing process is just that--process devoid of content--to varying degrees the content was organized by the use of Orem's concepts of self-care and self-care deficits, although sometimes reference was made back to Henderson's needs approach. (Henderson and Orem can be seen as belonging to a similar--making up

the deficits--school of thought). Sequencing followed a mix of health-illness and developmental continuum (i.e, courses moved from health or wellness to increasingly serious disturbances and/or from birth to old age).

In comparison with the medical model, the nursing process substitutes for signs and symptoms, diagnosis, treatment, and prognosis, allowing similar content to be covered as in traditional curricula but with a "nursing" focus. This may result in only slight reorientation of content, perhaps no more than existed in the old "medical model" curriculum, where the doctor's lectures on medicine and surgery were followed by the nurse teacher's lectures on "nursing care of the patient with ...." The use of Orem was most apparent in the organization of the "basic nursing care" component, and is not carried through to any great extent in the more specialized areas.

The use of nursing process is understandable against the background of its wide-scale introduction into Australian hospitals. The accreditation manual put out by the Australian Council on Hospital Standards mandated a systematic way of delivering nursing care, citing as an example "the nursing process." This was widely seen as prescription of this approach.

The popularity of Orem is interesting, since some reference to Orem occurs in almost all documents, either explicitly or implicitly. Orem originally published her ideas in 1970; yet they do not appear in Santora's review of the U.S. documents (1972-1978), adaptation then being the most popular choice. Perhaps the second, more elaborated edition of her work in 1980 captured more attention.

Centrally, Orem's approach constitutes a more active "patient," a self-care agent whose capacity for self-care has been impaired in specific ways by lack of knowledge, will or power. The role of nurses is to make up the deficits in those areas which fall within their domain and to do it in such a way that the patient regains self-care agency as quickly as possible. It is thus highly consonant with Western individualized views of the person as functioning as independently as possible, relying on others only when absolutely necessary. The definition of "absolutely necessary" can, however, be seen to be culturally dependent and dependent also on changes in medical treatment.

The trend in medical treatment toward early ambulation and early discharge, whatever its medical and economic justification, is consonant with the "independent" approach. A whole range of hospital practices have changed. Extended periods of "bedrest" have disappeared, nursery care for the newborn has been replaced by "rooming-in," restricted visiting of their children by parents has been replaced by an "open door" policy, and custodial care of the elderly and disabled has been replaced by habilitation/ rehabilitation. Some changes have been justified on medical grounds (e.g., early ambulation prevents pulmonary embolism) and others have come about because of consumer demand (e.g., rooming-in, staying with sick children in hospital). The use of Orem is highly consonant with such trends.

In Orem's approach, care is made visible as a caring stance directed at identifying self-care deficits and as caring activity

directed at meeting them. Although this can be seen as an important part of care, it does not make visible the care that goes beyond meeting individually-located self-care deficits. This is explored in more detail in Chapter XI.

Environmental/Social Curriculum

This curriculum is marked by the extent to which it emphasizes community, society, and environment throughout in a way that could be summarized as "nursing and health in a multicultural society." A very community-oriented approach to nursing is set against a background of concern with both the physical and social environment and with an orientation toward the nurse as change agent. Individuals, while recognized as such, are seen as part of a larger whole, thus moving beyond the predominantly individualistic holism of the other documents.

The organizing themes of the framework are health, development, the changing environment, and nursing, but health is seen as influenced by the extent and frequency of environmental change and development is seen as context-embedded, rather than as an individual trajectory.

> In this context of health, development and change, the individual is not seen in isolation, but as a member of a family, a group, a community and workforce. The development of every individual is influenced by his/her own family and social environment. That individual also influences the development of each group of which he/she is a member.... The multicultural nature of Australian society is reflected through these social groups and adds further dimension to the facilitation of optimal health for every individual.
> (HAC, 1984, p. 19)

The attention to workforce and industry was unique to this curriculum and was carried through in an emphasis on occupational health.

The person primarily responsible for this curriculum had a strong community/occupational background and was working in an institution which provided courses for health inspectors (environmental health) in addition to its traditional base in agricultural and food sciences. This background, rather than any particular nursing model, seems to account best for the shape and emphases of this curriculum, although mention is made in the philosophies of Henderson, Orem, and Leininger.

Nursing/People Curriculum

The overall framework of this curriculum, was very simple, with the two themes of nursing and people seen as being linked by the practicum. Despite a stated commitment to holism as greater than the sum of the parts, in the description of course structure it is stated that,

> Students will then appreciate that the study of the recipient of nursing care i.e. people (sic) can be approached from two different but complementary perspectives, biological or psychosocial. (NRCAE, p. 42)

However, the "people" component was broken down into three modules, People and Health, Human Biosciences, and Social/Behavioural Sciences. Through the People and Health module in first year, an effort was made to set up a holistic organizer for the more discipline-based studies.

The apparently simple organizer "nursing" becomes more complex as one progresses through the document. Nursing becomes identified with the nursing process performed for people "regardless of their state of

health or illness, at all levels of health care, and in community and hospital settings" (p. 13), which, interpreted literally, is a very tall order even though it is of a piece with many statements elsewhere in the literature that universalize the role of the nurse. This is then narrowed to a stress framework for consideration of both health promotion and the needs of the ill, thus targeting intervention at the primary, secondary, and tertiary levels.

The medically-oriented frame of reference is specifically rejected because of the perceived need for nursing to develop as "an independent profession." Nursing content is identified under those themes; the profession of nursing, the nurse as communicator, and the nurse as clinician. It is under the last that some reversion to "the medical model" takes place, despite its specific rejection.

The apparently simple framework of this curriculum thus tends to cover a much more complexly layered set of ideas (confusion even) about where to go once "the medical model" is rejected. While this can be seen as being true of all the curricula, this one represents in a more acute form the dilemma of too many ideas insufficiently worked through to provide coherence. It is a very difficult curriculum to generalize about.

The curriculum for this institution was extensively re-written and re-accredited in 1988, using a broad nursing diagnosis framework, with nursing content organized around the human response patterns of perceiving, feeling, knowing, exchanging, communicating, relating, valuing, choosing, and moving (Carpenito, 1987). The institution saw an important consequence of adoption of this patterning as being "the

eschewing of a body systems approach," going on to state,

> Previously, nursing specialties such as Medical/ Surgical Nursing, Mental Health Nursing and Developmental Disabilitiesi Nursing were offered as distinct and complete units. Conceptually, we have attempted to define a core body of knowledge and practice relevant to the discipline of nursing in any setting for the beginning level practitioner. (NRCAE, 1988, p. 37)

The way nursing knowledge is divided up and organized is seen as more focused around human experience.

> Utilization of the proposed nursing model provides a theoretical base for nursing related first and foremost to the client, as a person or group of people, not to the illness or disease. (NRCAE, 1988, p. 32)

Despite a dramatic shift, in some ways this situation could be seen as continuing the People/Nursing framework of their earlier submission.

Carpenito (1987) makes clear that the area covered by nursing diagnosis is not the only role of the nurse. She argues that medical diagnosis should not be contorted (or translated) to fit the nursing diagnosis framework. Logically, then, the medical knowledge that nurses need requires something beyond the nursing diagnosis framework. This institution attempted to resolve this problem by developing "pathogenesis" units which could be regarded as covering the area of medicine. The boundary between medicine (or doctoring) and nursing is a shifting one, as Carpenito acknowledges. It also varies (as any nurse knows) with the time of the day, type of health care setting, geography, and culture. The adoption of a nursing diagnosis approach thus forces nurses into a certain "bilingualism," as I have argued. However, such bilingualism is already incipiently present and nursing

diagnosis only makes it explicit.

Health-Illness Continuum/ Health-Illness Trajectory Curriculum

If the curriculum from one institution with a long nursing involvement showed a tendency to try to include a wide range of ideas, although finally coming down to a systems model, this curriculum from another college with a ten-year involvement in teaching registered nurses demonstrates the perils of skepticism. (It is my own employing institution, although I was absent during the initial curriculum development phase, as previously discussed.)

Over the years, this institution had developed a strong critical evaluative approach to the nursing literature, particularly with regard to the nursing theory movement and the "nursing process" approach to practice. The critique of nursing theory accepted the importance of theoretical development in nursing, but was critical of reified "nursing theories." Nursing process was seen as an excessively logistic and time-consuming approach to nursing practice, which was not distinctly nursing but could be applied to anything. It was process devoid of content which had to be drawn explicitly or implicitly from elsewhere. The use of nursing process alone usually meant that medicine was implicitly drawn on, yet nursing theories were not developed in such a way that they could provide the content.

This institution was skeptical of the belief that nursing would gain professional standing simply by developing an independent body of knowledge, their skepticism informed by feminist critique. Thinking

about medicine had been reoriented toward seeing it as a body of knowledge on which all health professionals draw for their practice, neither built up exclusively by doctors nor practiced exclusively by them. "Doctoring" was thus one way of drawing on a common body of knowledge, shared by all health professionals.

When it was required to develop a basic nursing curriculum, this institution was poorly placed, given the prevailing ideological climate described earlier. The first submission (which was rejected) followed a health-illness continuum for sequencing content, the selection of which appears to be governed by pragmatism (i.e., it covered all the areas required by single register preparation at a depth judged appropriate for beginning practice). The placement of maternal child nursing with the specialties in the third year of the program was more than somewhat at odds with the health-illness continuum adopted. The work of Benner (1982) and Benner and Wrubel (1982a, 1982b) was used rather loosely to support the arrangement and structuring of clinical nursing areas in the rationale, although it is hard to see evidence of this in the content. It seems an inappropriate use of Benner's schema, which starts with the beginning practitioner which the course was intended to produce. In endeavouring to avoid ideas of which faculty had been critical, faculty fell into an atheoretical void and thus back on to a modification of hospital-based programs (for which they were criticized).

The document is also at fault in not addressing the reasons for rejection of commonly espoused ideas (nursing cliches as faculty saw

them). In the absence of such argumentation, the accrediting committee tended to assume ignorance rather than thoughtful consideration, debate, and rejection. The multiple authorship of course outlines against the pressures of time also led to a loss of coherence.

Although light on from an ideological viewpoint, the document was clearly informed by a vision of a better prepared, more flexible nurse who had developed basic understandings and skills in a wide range of practice settings. Because of the background described above, there was less discomfort with the teaching of medicine as a discrete area within the nursing content. Nursing process, nursing care plans, and nursing theory appeared as discrete content areas rather than being used as organizing frameworks.

Since there is no evidence to suggest that this curriculum would not have worked as well as any other (at the level of content it was similar to most curriculum documents of the same vintage), its rejection throws light on the hopes and expectations fueled by the movement of nursing into the educational sector. As in the USA, these related at least as much to the formal development of nursing knowledge as to the development of nursing students as beginning practitioners.

By the time I chaired a curriculum re-development committee to produce a document satisfactory to the accrediting committee, faculty had "dug in" to their positions and the process of re-development was a very difficult one. As a result, the new document produced incorporated much of the old, undoubtedly resulting in its limited

accreditation (for three, instead of five, years). I proposed the following rationale to faculty, in response to the accreditation "crisis."

> The student will move from simple nursing theory and practice to complex, the most complex skills being seen as involved with health assessment, health education and promotion and setting priorities within the health-care setting ("management"--a term I don't like at beginning practitioner level).
>
> At the same time, the student will move from community observations to low technology, high dependency settings to high technology, high dependency. From these she (sic) will move to habitation/rehabilitation (decreasing dependency and creative technology) and then return to community experience before beginning practice, learning the high-order skills of health assessment and health education for which her (sic) previous education and experience have now prepared her (sic). This roughly parallels the health-illness trajectory (from community, through the hospital, back into community). It also avoids students being left with the idea that high dependency, high technolgoy areas represent the peak of nursing skills (a problem with placing them at the end of the programme). (Dunlop, letter to Colleagues, September 17, 1984)

As an indication of the climate prevailing, this letter was signed (only partly in jest), "Yours in fear and trembling!"

Thus, the second version of the curriculum adopted a "health-illness trajectory" approach as the organizing framework for content, allowing faculty to maintain their skepticism of extant theories and common conceptual frameworks (for better or worse). The instituition's most recent document (accredited for the normal five years at the end of 1987) could be seen as an evolutionary, more sophisticated version of this approach. It redresses a perceived

imbalance toward the biological by development of a "behavioural nursing" strand more closely linked to the social and behavioural sciences. The term "behavioral nursing" is a loose one used to cover material related to the human experience of health, illness, and disability which is not tied to a particular disturbance of functioning and is thus without behaviourist connotations.

A concern for the development of nursing knowledge is spelled out in student-centered terms.

> Nursing knowledge, like that of other professions, is far from homogeneous and any attempt to form it into a single pattern, even for teaching to neophytes, straitjackets its development. A more open structure encourages a more multi-faceted approach to knowledge development.
>
> A central concern has been to develop courses which require research and development of material for teaching from sources outside as well as inside the nursing and medical literature. This makes it possible not only to initiate students into optimal current approaches to nursing practice but to situate them on the growing edge of nursing knowledge so that they can see how the knowledge base is developing and can be further developed. (ACAE, 1987, p. 14)

This institution was thus able to find, finally, an acceptably liveable formula for its general approach which was also acceptable to an accrediting committee, possibly because of its frank acknowledgment and discussion of the problematics of nursing knowledge (elsewhere in their document).

Discussion

Although the documents overall clearly show the strong influence of ideas originally developed in the USA, there is really no

curriculum that consistently follows a single model. (The curricula that come closest to this are the two which use systems.) Rather, the frameworks are put together from an eclectic selection of ideas, loosely organized to provide an organizing framework for sequencing of material believed to be necessary for the beginning practitioner. They are thus more in nature of organizing frameworks which the NLN substituted for its requirement of conceptual frameworks in 1982. It would be unduly simplistic to see content flowing logically from the development of these loose frameworks, as a rational planning model of curriculum would suggest.

As far as the shaping of nursing knowledge is concerned, these frameworks, on the whole, appear to be opting for a rather open approach, avoiding being tied too rigidly to any particular understanding to the exclusion of others. The one novel addition, from Kuring-gai College, is a clinical judgment model which incorporates an ethical component. At least six Colleges deliberately moved away from the nursing process as an organizer, suggesting some re-thinking of this area. There was a strong emphasis on nursing as caring, mainly spelled out in terms of meeting needs or making up deficits, using Henderson and Orem as references. But the connections remain loose.

Drawing on my own situated understanding, it is hard to see this eclecticism as anything but deliberate. Familiarity with the literature is clear in the documents but also came through in many informal conversations with the writers of the documents and in more formal discussions at meetings of the NSW Nurse Academic Forum (set up

to facilitate exchange of ideas after announcement of the tranfser). Although the guidelines required "the setting up of a model for the nursing curriculum," this requirement seems to have generally been interpreted as broadly as possible because of concern about being too tightly locked in. Thus, senior academics could refer to their curriculum being based "very loosely on Orem" and be understood (others smiled and nodded in sympathy).

A major concern was to preserve continuity with the past, often expressed as "not throwing the baby out with the bath water" or "not all things we did in the hospital system were bad--after all, it produced us" (laughter). Thus, the new developments were seen as building on what had gone before, rather than starting from scratch. There was concern (possibly exaggerated) that the accreditation committees had expected a too widescale ditching of the past. This can be illustrated by the somewhat world-weary remark of a senior experienced nursing academic to me in the context of this sort of discussion. "Sometimes, Margaret, we have to save the Registration Board from itself. I just bury the hospital-type content--but it's there."

While there was appreciation of the need to prepare nurses for changing roles, there was also concern to maintain preparation for established roles, largely situated still within the hospital environment. Thus, while curriculum framers had to keep one eye on the ideological weather vane, the other eye seems to have been fixed on the everyday practice arena where the graduates would work. The acceptance of the graduates by the skeptical "grassroots" RNS would,

after all, depend on their ability to function as acceptable members of ward staff, and this required some degree of continuity with the past. If institutions failed in this, it was they that would be judged and not the framers of guidelines or accreditation committees.

This can be understood as not allowing one's theoretical framework to crowd out (or overtake) one's commonsense understanding of the world of nursing. (Common sense in this context can be interpreted somewhat literally as the sense of nursing which is held in common by its practitioners.) Unable to find a framework that encompassed all such commonsense, multiple frameworks were employed and even then not consistently carried through in content.

This is not to suggest that the documents reflected only the status quo. The enterprise overall was informed by a broader vision of nursing very much in accord with the spirit of the guideline documents. The emphasis shifted much more toward health, away from the disease model, and much more attention was given to the place of the behavioral sciences.

Nursing was seen as having its own body of knowledge, although the shape of that knowledge remained unclear. Perhaps it will be some reassurance that Emden (1988), in an Australian study, found much of the same uncertainty about clearly defining their discipline among other academics--in fields as varied as education, town planning, religion, dentistry, and music. The typical nursing statement, which is similar to those in other fields, she cites as,

> Nursing is not explicit ... we can't pin nursing down ... it's hard to agree on any area that is absolutely nursing unique ... we introduce

> students to the practice of nursing rather than the discipline, at the moment we don't have much else to introduce them to ... our body of knowledge is evolving ... there is definitely an emerging discipline. (cited in Emden, 1988, p. 40)

For Emden, the difference is that other fields do not appear to place the same emphasis on theory as nursing does, which seems to mean that they are much less concerned with a neat, bounded encapsulation of their field.

The transfer of nursing education thus opened up "a clearing" (to use Heidegger's term) for nursing's development. It was not a situation of radical freedom, but of situated possibility. It remained linked to the past and present, while reaching toward the future, thus partaking of the same temporality that shapes other human actions in the world. On the whole, curriculum framers seem to have discovered that no single formula sufficed for giving shape to the enterprise.

CHAPTER XI

CONCEPTS UNDERLYING THE MODELS

It is one thing to look at the frameworks overall and another to try to understand the major ideas underlying the words used. Santora (1980) simply does a word count, equating words unproblematically with concepts--man (sic), nursing, nursing process, health, illness, family, community, social systems, and environment. But these bald terms tell us little about the underlying concepts informing their use. For this one needs a more interpretive approach.

The overall impression in the NSW curriculum documents is one of words tumbling over one another in an effort to express a very complex reality. In order to provide some sort of structuring for this reality, I will use the "metaparadigm," human beings, environment, health and nursing, despite reservations about its usefulness as a metaparadigm. It is heuristically useful here because many of the documents use this sort of ordering, either explicitly or implicitly.

Human Beings

The curricula examined by Santora almost universally provided some description of man (sic) in terms of a bio-psycho-social spiritual being (Santora, 1980, pp. 22 and 36). Similarly, all NSW curricula contain some discussion of the nature of human beings (individuals, persons, or man/woman), most using a similar interactive holism formula. The basic description was of a bio-psycho-social being to which some institutions added cultural (2), spiritual (5), or

emotional (2).

Although five institutions spoke about a person or individual being more than the sum of the parts, only two institutions elaborated this in a way other than interaction of the parts, one examining the concepts of "lived self" and "lived experience" and the other seeing individuals as part of a larger whole.

Other concepts used to describe human beings were self-care agent, possessor of needs, situated on a developmental continuum and adaptor to stress. The choice of concepts here obviously related to the model(s) used to organize the curriculum. In addition, three colleges introduced the concept of "healthy death" (which does not seem the most appropriate way of referring to a legitimate area of nursing discourse concerning the good death).

The interactive holism so commonly espoused provided the rationale for selection of support subjects in the biological, behavioural, and social sciences. However, only one institution which built "spiritual" into the definition provided explicit content in this area and, in the case of institutions including "emotional," it was hard to see any following through beyond the teaching of psychology which was already included anyway.

Discussion

The dominant paradigm for self-understanding divides the human being into parts, which are the subject of separate sciences. There is a general belief in the interaction of these "parts," but relatively little attention is focused on such interactions in terms

of explicating how and why it happens. It is not surprising that in nursing curricula, as in the nursing literature generally, there is an acceptance of the interactive holism approach, given that much of what nurses see in their practice cannot be understood in terms of a single scientific discipline. In order to incorporate this existential knowledge, the category of interactive parts tends to increase, thus increasing the scope of appropriate (? necessary) supportive subjects, threatening curriculum overload.

The most interesting alternative approach in these documents was the "lived experience," followed through in content by use of literature. However, the curriculum still included the usual support subjects as well, involving the same problems of overload.

Although human beings are identified as part of nursing's "metaparadigm," there is, as yet, little material put together that would provide the basis for a more "whole" approach to learning (or thinking) about them in line with nursing's philosophy. Such material as exists is scattered throughout the literature of the various disciplines and requires considerable effort to draw together and develop.

In Chapter V, for example, I raised the issue of embarrassment, in the context of care of the private body, something that is embarrassing for both the receiver and giver of care. Lawler (1989) has recently explored this area mainly from the viewpoint of the nurse, but in order to do even this, had to draw very widely on a very scattered body of literature.

While what has been tagged psycho-social understanding is

important, the disembodied nature of much psychological and sociological discourse means that it tends to "slide past" nursing concerns, as nurses deal with patients in their embodiment. The biological paradigm, focused on structure and function, is even more inadequate in this regard.

This is by way of suggesting that it may be possible (and very useful) to explore more carefully the sort of knowledge about human beings that is of particular concern to the nurse. The beginnings of such an approach can be seen in the Kuring-gai CAE (1984) document and the more recent Armidale CAE (1987) document. It is an area, in short, that could benefit from being raised as problematic and taken up in the nursing discourse.

Environment

This is rather sketchily dealt with in almost all the documents, coming most to the forefront in the Hawkesbury Agricultural College submission (1984). Apart from this, the nonhuman environment was mentioned not at all, or only in passing and what attention there was focused predominantly on the human environment of family, community, culture, nation, and world.

Three colleges used the term "health environment" which seems like a useful narrowing of the term. While it is possible to see the whole universe as impacting on health, as I suggested in Chapter III, nursing's focus tends to be directed (quite appropriately) to the micro-environment (physical and social) close to the patient (not just geographically). Even where broader terms are used at some stage, it

is the closer terms of family, community, social groups, cultural groups, and social networks that receive the most attention--that recur throughout the documents, but as a minor theme compared with the focus on the individual.

On the whole, there was little real attention to environment. It performed a very similar place-keeping function to what it does in the nursing literature generally, as a very unfocused and unexamined concept (see Chapter III).

It is probably worth noting that in the existential world of nursing practice it occupies a very important place. But the theoretical tendency to focus in on the patient or the patient-nurse dyad makes it tend to slip from view. (This is discussed later in this chapter in considering the nurse as manager.)

Health

As Benner and Wrubel (1989) point out, until 200 years ago, health was understood as soundness of mind, body, and spirit, this view gradually being replaced as modern medicine developed by a view of health as absence of disease. This view in turn is changing toward a more positive approach--one which sees health in terms of a state of presence rather than absence. This change is strongly reflected in the NSW curriculum documents at both philosophical and course content level. Although the change is more marked at the philosophical level, course content also reflects, to varying degrees, an attempt to think through the implications of a positive view of health.

Benner and Wrubel (1989) summarize the alternative views as

health being seen as an

(1) ideal state

(2) ability to fulfill social roles

(3) commodity

(4) human potential

(5) sense of coherence

(6) well-being

They argue for well-being, defining it as congruence between one's possibilities and one's actual practices and lived meanings, based on caring and feeling cared for (Benner & Wrubel, 1989, p. 165).

The view of health as commodity appears to have a certain continuity with the old "health as absence of disease" view, in this case "commodities" being purchased to make up the deficits. However, its separation draws attention to the latest development of this "technological self-understanding" approach which packages "health" in the form of health club memberships, an instrumental approach to friendship and business and a shaping of the body to some ideal healthy "norm". A huge and growing commodity industry now supports this pursuit of health as commodity and the shaping of the "self" to some ideal "norm" by therapy is now also part of the movement. This approach was refreshingly missing from the NSW documents, as was health as an ideal state, most clearly seen in the World Health Organization (WHO) definition of health (1946).

In a sense, use of the health-illness continuum (which was almost universal), tends to form up health as an ideal state at one end of the continuum, but the use of the continuum reduces the static nature

of health as ideal state which Benner and Wrubel (1989) critique.

The extensive use of Orem in the curriculum documents led to the widespread use of a nursing version of the second, i.e, ability to fill social roles became the ability to perform activities of daily living or to meet self-care needs. However, this view of health was never used alone, but usually in combination with ideas about health as human potential, key phrases being "optimal functioning," "human fulfillment," "maximum health potential," and "maximum level of holistic functioning."

The nursing version of the second, health as the ability to perform activities of daily living, is somewhat narrower but of the same genre, and is understandable given that nurses so often encounter people at times when even the most basic ability to fulfill social roles is beyond them. Yet, at the same time, the curriculum documents appear to recognize the limitations of such a view, and so juxtapose elements of other paradigms.

In addition, one college recognizes that health characteristics change with the person's cultural and philosophical viewpoint which borders on the idea of health and coherence (CCAE, 1984, p. 17). Another college states,

> When healthy, a person identifies with their body and faces the world acting as an essential unity. When less than healthy, the body impedes choices and actions and is no longer fully responsive. The body intrudes on a person's existence. (KCAE, 1984, p. 40)

This view, while also within the ambit of coherence, is very close to the account Benner and Wrubel (1989) provide of health as well-being.

Two colleges adopted a stress/adaptation view of health and a further one modified it to "purposeful adaptation." The pure adaptations approach seems closer to "ideal state" idea of health--that the healthy person is one who is adapted and/or who adapts her/himself (depending on how active or passive one wishes to make the process).

There is quite a strong discourse about health in the health care literature and most institutions indicated in their course content their intention of introducing students to this discourse. The aim seems to be to provide the students with a vision of health that goes beyond the deficit approach which the world of practice has generally adopted, situated as it has been largely in hospitals and nursing homes. The changing range of nursing practice seems to require such examination of different ways of thinking about health.

Nursing

What vision of nursing is conveyed through the curriculum documents? There are many words used to describe nursing activity, suggestive of an occupational group whose role is changing, but is still in a period of flux.

Nursing itself was variously seen as an interpersonal process, a clinical practice discipline, the application of health care, an applied science, both an art and a science, and a discipline or developing discipline. The most common emphasis was on nursing as an interpersonal process, an emphasis which suggests nursing is projected to remain a people-oriented activity. This reading is supported by

the emphasis placed on caring in all of the documents.

Caring

By and large, caring is seen as meeting needs, assisting with activities of daily living or making up self-care deficits in line with the popularity of the needs-based approach in the conceptual frameworks. It is thus a very practical form of activity. One document describes the nurse as "protector, healer and comforter" (CCHS, 1984, p. 14) and another situates caring and/or curing within an imbalanced relationship.

> Nursing is a caring and/or curative activity placed within an imbalanced relationship. The therapeutic intent of the clinical relationship tends to place the patient in a vulnerable role vis-a-vis the nurse. The latter is expected to acquire and maintain a specialized body of knowledge and skill. Even the diagnostic ability of patients which brought them to the relationship is superseded by a more scientific attempt to categorize the patient's problem and decide on appropriate interventions aimed at restoration of optimal health. (KCAE, 1984, p. 39)

This document, which emphasizes the lived experience of the patient, thus overrides that lived experience with "science," with the nurse placing a "scientific" template or grid on that experience. However, elsewhere in the document reference is made to mutual teaching in dialogue between the nurse and patient.

> In the clinical relationship there must be interpenetration of minds as well as physical contact: the nurse and patient "teach" one another in dialogue. The idea of dialogue in the relationship implies that the nurse is genuinely interested in what the patient has to say; that the nurse takes the patient seriously as a person and regards their thinking and

> experience as valid and important, and that the nurse expects to gain something from the exchange as well as give ... attitudes of respect for people, unconditional acceptance of the person, interest in their thoughts and experience, equality, and a willingness to learn from others is (sic) basic to the clinical relationship ... there is an imbalance of scientific knowledge which places the heavier burden of responsibility on the nurse. (KCAE, 1984, p. 25)

Thus "scientific knowledge" takes pride of place even in the acknowledgement that nurses also learn from patients. It is reasonable to ask what this "scientific knowledge" is. There is, of course, modern scientific medicine which transforms the patient's lived experience into signs and symptoms on which to base a diagnosis suggestive of prognosis and treatment, and it may be the nurse's greater access to this that produces the imbalance. While there is also a body of nursing knowledge, very ltitle of it could be seen as scientific. Indeed, this document rejects the idea that nursing is to be seen purely as a science.

> We believe nursing is a distinct discipline; it falls somewhere between being an art and a science but is distinct from both of them.
>
> Nursing is a habit of practical reasoning refined and perfected by experience in dealing with patients. (KCAE, 1984, p. 22)

It may be at least as accurate then to see the imbalance as residing as much in an imbalance of experience as in an imbalance of scientific knowledge (in terms of this document's account).

There does seem to be an imbalance in the nurse-patient relationship which would exist regardless of the "scientific" knowledge of the patient, that would exist, for example, if the

patient were a very knowledgeable and highly skilled nurse or doctor. The "therapeutic intent" of the relationship gets closer to it, if therapy is considered broadly to include both care and cure (as the context here suggests). The imbalance is that between the carer and the cared-for in a cultural context that valorizes "independence."

In the document under consideration, the imbalanced relationship is seen as redeemed by trust, responsibility, compassion, and clinical judgment, all of which are examined in detail. In particular, a sentimental view of compassion is especially rejected.

> Compassion means genuinely feel (sic) the existential situation of the person who is bearing the burden, or who anticipates with fear and anxiety the potential burden, or illness or disability. We can never wholly enter into the state of being of another human, but we must try with all our energy to feel to the fullest extent, our sensibilities will allow. It is our failure to feel along with the patient that leads to the assertion which is frequently heard to-day, of patients' experiencing humiliation and being demeaned. (KCAE, 1984, p. 27)

Thus, compassion is seen in terms close to its root meaning as "presencing with" the person being cared for, rather than "feeling sorry for." The approach to nursing being espoused here thus is quite congruent with Benner's (1984) account of expert nursing practice and also with Gadow's (1986) account of the redemption of cure by care.

Yet, in our daily lives, the care we receive from others is often redeemed by the care we extend to them, whether in symbolic or fully equivalent terms (or the range between). It may be worth acknowledging and exploring the ways in which patients/clients seek to return the care and concern that nurses extend toward them that at

least partially redress the imbalance of the relationship. This is suggested in this document by the idea of mutual teaching in dialogue, but could be explored beyond this. This is to suggest some correction of view of caring in nursing as a "one way street" consonant with our traditional model of the therapeutic relationship.

Although not spelled out with the same detail, other documents demonstrate a similar "doing for" approach to caring, for example.

> Fundamentally the role ... is caring. Such caring is manifested in those elements of the nurse's role in which she (sic) is required to assist, teach, counsel and show concern for those whose health status can benefit from nursing intervention. The concept of the nurse as a caring person has been an integral part of the philosophy.... Despite the ambiguity in the definition of the role of the nurse, there is general agreement that the basis for nursing actions is the needs which are manifest in those requiring care.... The needs-based model, however, is incomplete without the nursing process. (U of W, 1983, p. 3)

Another document is even more explicit about the "doing for."

> Nursing
> - is a helping or facilitating practice in that it:
> (i) acts for, or does for another;
> (ii) guides another;
> (iii) supports another (physically and psychologically);
> (iv) provides an environment that promotes personal development in relation to becoming able to meet present or future demands for action
> - teaches another

As this is taken from Orem (1980, p. 61), whose ideas occur in almost all the curriculum documents (including the first one cited in this section), the predominant approach to caring in the documents can be identified as an Orem-type approach.

The Self-Care Deficit Approach

The strength of this approach is that it requires nurses to question whether they are "over-doing" for the patients, that is, doing things that patients could be doing for themselves, thus reducing them to a position of greater powerlessness than necessary. It is very consonant with Western individualism which places responsibility on those needing care to become independent of it as rapidly as possible to the fullest extent possible. This applies to both the developmental needs of children and the needs of those disabled, temporarily or permanently, during the life-span. Independence is a primary goal, and needing care is a negative experience, with the likelihood that care itself will be perceived negatively--become an "embarrassment" (Benner, 1989), and therefore become undervalued, particularly by those who do not see themselves in need of it, or at times when people do not see themselves in need of it.

Yet such independence from care is based on illusion, on a closing of the eyes to the care which surrounds us in our daily lives. The feminist movement has drawn attention to the way in which men rely on care which certainly goes beyond doing for others what they cannot do for themselves, whether as wife, secretary, nurse, or lover. Many women can now testify to the difficulty of trying to persuade men to meet their own self-care needs even in the most basic physical sense. (This is only to pick up one of the more obvious examples, made visible by feminism.)

Self-care needs are thus nowhere near as obvious as they appear

at first glance. They are by no means universal (as Orem suggests) but will vary according to gender, age, class, and culture, to suggest the most obvious variables. Socialization into the dominant culture provides nurses with access to "normal" self-care expectations with regard to age and sex (at least in terms of white middle-class norms). While people do in varying ways and in varying degrees exercise self-care, there is no universal category of self-care activities, and therefore no universal category of self-care deficits which the nurse can make up. The danger is that nurses might substitute their own self-care patterns for those of the patient. To a certain extent, this can be counteracted by sensitizing nurses to individual, social, and cultural differences through studies in the behavioural sciences, but Orem's general approach treats universal self-care needs as an unproblematic, self-evident category.

The illusion of the independent person conceals the enormous degree to which we are interdependent in the modern state, through the complex infrastructure that supports our everyday activities. This is usually experienced as ready-to-hand, in Heidegger's terms, and is noticed only when it breaks down. Much of this could be regarded as the contractual area of our inter-dependence, although even in this contractual area we expect people to "take care"--to focus their concern on the welfare and safety of those who will use the infrastructure. Nurses themselves rely on a very complex infrastructure to support their work.

But beyond this, we are all reliant for our sense of well-being on mutual caring which is often symbolized in "unnecessary" (in the

strict sense) assistance with self-care needs. These range from the person who offers assistance to a stranger struggling with a map of an obviously unfamiliar city to the intimate interchange between familiy members, lovers, or close friends.

This is by way of arguing that caring cannot be delineated in terms of meeting unmet self-care needs, whether of the universal, developmental, or health-deviation variety, although Orem's theory can function as a maxim to warn us against the dangers of the "taking-over," controlling approach to care. Any stricter application of her theory would be experienced by recipients as non-caring. The sense of being cared-for does not arise from others doing for us just what they absolutely have to do.

On the other hand, we value our independence and resist the sort of care that threatens to take us over completely, finding it, as the first document cited here states, "demeaning and humiliating." It is this approach that Orem's theory acts as a maxim against, and this, I would argue, is its main contribution to nursing's self-exploration.

But the sort of care that counts is not reducible to a simple "making up self-care deficits" formula. There can really be no substitute for placing oneself as sensitively and imaginatively as possible in the world of the other in order to provide appropriate care (as in the Kuring-gai CAE account of compassion). At the same time, to become submerged in such a world would be to close off one's capacity to help, based not only on science but on practical reasoning built up by experience of caring in nursing as in other areas of life.

Since caring is seen in all the documents as central to nursing,

it seems important to continue to explore it beyond the simple formulae of "meeting needs" or "making up self-care deficits," which suggest a reductive view of care, if taken literally. The difficulties of scientizing care have been dealt with elsewhere (Chapter IV). The tensions that are set up for nursing by its acceptance of a caring mandate and its desire to scientize its practice are illustrated in one of the documents.

> It is our belief that nursing is a caring profession and that the caring role is being expanded to include not only the care of the sick, but also the promotion of health and care in the prevention of illness.... Caring is considered to be essential to human development, growth and survival and the nurse needs to be aware that caring behaviours vary transculturally in priorities, expression and needs satisfaction.
>
> Effective nurse education must reflect the nature of health in a dynamic changing community, but still maintain the concept of the nurse as a caring person who respects the individuality and integrity of others. In order to achieve this there is a need for a sound knowledge of the biophysical as well as social and behavioural sciences. It is our belief that caring is an interpersonal skill and that high quality of patient care cannot be achieved in the absence of knowledgeable and skillful nurses.
> (HAC, 1984, pp. 17-18; emphasis added)

There seems to be an implicit recognition here that knowledge of the sciences is not enough--it is necessary, but not sufficient. There is acknowledgment, following Leininger (1980) that caring behaviours vary transculturally, but caring itself is dealt with by reference to Henderson (1967) and Orem (1980) which are essentially needs/deficit views of caring. The point is that needs/deficits could be met without the necessity for the nurse to be "a caring person,"

suggesting that the author of this document believes that what is important is not only that needs are met, but the way they are met (a position with which Henderson would agree).

The problem is that needs are not a delimited category. Willard (1982), in a discussion of health needs, argues cogently that human needs (including health or medical needs) are not facts but values because needs are goal-oriented and goals are things that people value. He also argues that "need" functions as a motivational term to provide emphatic underlining of our wants and desires and that "disagreements about what people need are disagreements in attitude toward, and emotional attachment to, things variously considered to be valuable" (Willard, 1982, p. 261). He concludes,

> Medical professionals, therefore, should not be led into believing that they face a conflict between health needs as facts and rights as values of their patients. What they do face is the problem of how to deal with the rankings, the ascribing of priorities, among the various values which human beings hold, including the values of health, life and freedom from pain and suffering.... Medical professionals, like the rest of us, must beware of thinking of needs, health or otherwise, as value-free facts about people, lest the results of preference, prejudice, professional blindness, failure of moral nerve and social conditioning, parade as the grand and obvious discoveries of objective scientific method. (Willard, 1982, p. 273)

At least at the micro-level (where nursing usually operates), there is good reason to believe that it is only the sort of compassion (as described in KCAE document) or caring in the terms of Gadow and Benner that provides a way of avoiding the imposition of our ideas of needs upon others. To the extent that Orem's work is regarded as a

"scientfiic" framework for nursing practice, it is open to a similar objection to the one outlined above.

Educative Role

All documents mention the "teaching" role of the nurse, which is not surprising given the NRB competency guidelines, where competency 4 was health promotion and competency 5 habilitation/rehabilitation. In addition, competency 6 was communication and interpersonal skills. Thus, of the seven competencies prescribed, three had a reasonably strong relationship to a "teaching" role considered broadly. The terms used to cover this area included teacher, counsellor, guide, development facilitator, health-care facilitator, and communicator. In addition, reference was made by two colleges to the nurse as assisting with the identification of health goals, and one college referred to the rich notion of mutual teaching in dialogue (cited earlier).

At this basic level, the educative role tended to be seen as occurring on an individaul basis, although participation in health promotion programs was also seen as part of competency 4. The strongest emphasis, however, was on an individualized role. As one college puts it,

> The close personal contact that nurses have with patients, both in hospitals and community, provides opportunities for the nurse to act as patient advocate-interpreter as well as health teacher and health promoter. (MCAE, 1984, p. 14)

In discussing this model, they go on to say,

> This model represents:
> (1) a nurse who
> (i) seeks to promote health by supporting the individual in the maintenance of a healthy life-style.
> (ii) will educate the patient in approaches to maintenance of health.
> (iii) will intervene as necessary to assist the individual to return to health.
> (MCAE, 1984, p. 18)

Another document explicitly links teaching to the caring role.

> [N]ursing is a unique "caring" service concerned with the aim of helping and teaching individuals, families and groups, to manage their own health care in all phases of health and illness. (Av. CAE, 1984, p. 22)

Thus teaching, within a caring context, is directed toward the goal of self-care in accord with their overall needs-based approach.

In its discussion of the role of the nurse in its 1987 document, Armidale places this aspect of the role in its broader context.

> Like other health professionals, nurses are also being encouraged to become more involved in preventive and educative measures--in health-screening activities, in general and special group education, in encouragement of healthy life-styles and in assistance to support groups for those with special problems. This also can be seen as a useful and rightful extension of the traditional nursing role, given nursing's historical involvement in the public health movement in the last century and early years of this century. (ACAE, 1987, p. 15)

Nursing is thus seen as involved, among other things, with "educative care" (ACAE, 1987, p. 15).

Although teaching is seen as part of the nursing role, it is hard to find evidence in the documents of specific attention to the development of teaching skills. This is interesting, as all but two of the institutions involved were former teachers' colleges and still

have major involvement in the preparation of teachers. As an exception, Armidale, by including from the beginning a health education and promotion unit, did provide a place for addressing teaching skills, the aim of the course being stated in the following terms:

> This course is designed to emphasize the teaching role of the nurse. Using information from a variety of specialized fields ... students will gain the knowledge and skills necessary to effectively teach and promote concepts of health and wellness to individuals, groups and communities. A variety of teaching strategies will be explored and extended by an identification of the various contexts in which they can be successfully utilized. (ACAE, 1984, as revised 1985, p. 132)

However, on the whole, one is struck by comparative neglect of the development of the teaching role in the course content, particularly in comparison with the attention given to more traditional areas of nursing function.

This suggests that implications for the curriculum of endorsement of teaching as part of the nursing role have not yet been sufficiently thought through. The assumption seems to have been made that knowing about health and illness and developing basic communication skills would be adequate for the situation. This may be the case, but I do not think it can be assumed. If teaching is to be incorporated into the knowledge base of nursing, there is a need to look much more carefully at the sort of knowledge and skills involved in the everyday work of nursing teaching as part of clinical practice. This would be to take seriously what Benner (1984) has identified as the teaching-coaching domain of nursing, on the assumption that there are educational ways of enhancing its development.

Independent/Dependent Functions/Health Team

Three documents follow Henderson (1960) in distinguishing explicitly between independent and dependent functions of the nurse. However, where Henderson saw the dependent function as related to the medical regime prescribed by the physician, these documents refer generally to other health care professionals rather than specifically to physicians.

> Needs are considered in preventative, therapeutic and rehabilitative aspects of health-care. Within each of these contexts there are two facets of the nurse's role, one dependent, which is initiated by another health professional and the other independent, which the nurse herself initiates, monitors and controls. (U of W, 1983, p. 3)
>
> We believe that aspects of all these elements are nursing-specific and complementary to the medical treatment regime and paramedical and medical care processes.
>
> In addition, and complementary to these unique independent functions, the nurse also performs functions which are dependent upon directions from medical and paramedical members of the team. (NRCAE, 1984, p. 16)

The third document simply refers to "application of dependent and independent nursing behaviours" without further specification (Av. CAE, 1984, p. 27).

It is not clear that broadening the statement of the dependent functions in this way is an improvement. While it is obviously an attempt to move nursing ideologically away from its doctor-specific role, it increases the possible controllers of nurses' dependent function and thus the range of possible dependent functions in an imbalanced way which fails to recognize the mutual dependence of

health-care workers. (In its 1988 submission, Northern Rivers still mentions dependent and independent functions, but only in passing--NRCAE, 1988, p. 29).

Other documents used a health team approach (or collaboration with other health care professionals) to cover this area of nursing function, for example,

> Nurses seldom practice in the isolation of total independence. Rather they seek to enhance their contribution to human health and well-being through constructive relationships with professional colleagues. Thus, the graduates, as members of multi-disciplinary health-care teams, will be required to work co-operatively, with other health-team members. (Nep CAE, 1984, p. 20)
>
> Nursing can, therefore facilitate the various elements of care provided by other members of the health-care team. (MCAE, 1984, p. 14)
>
> The delivery of care should reflect, in turn, co-ordinative and collaborative abilities in the graduate with a commitment to working with other health professionals to achieve the best quality of care. (CCHS, 1984, p. 13)

This seems a more useful ideological move, even if there is a current gap between ideology and reality--although one can question the common reading of the reality. In the complex health care system we have today, health care professionals are interdependent, as well as being dependent on large numbers of auxiliary, secretarial, and other staff who provide the infrastructure support services. In this context, the ideological move is to shift nursing from the infrastructure support services to full collegial relationships (currently, it is somewhere betwixt and between).

One can be skeptical about health team ideology in the context of

the gate-keeping function of the medical profession which continues to be legally mandated in most circumstances and is still strongly mandated by tradition. However, human beings are not only constructed by, but construct their reality and placing emphasis on the health care team approach can be seen as a move in the direction of reconstructing current relationships. Other health professionals, too, have a stake in reconstructing their relationships with the medical profession, although they are probably less interested in reconstructing their relationships with nurses. Nevertheless, endorsement of the health team approach by nurses can be seen as a shrewd political move to garner support for a change in the relationships between health professionals.

Within the context of curriculum, an approach that emphasizes collegial relationships seems likely to produce nurses more prepared to contribute on an assumption of equality from their own base of knowledge and experience, which, in turn, validates and strengthens that base. While some documents avoid the issue completely by concentrating their focus only upon nursing, there seems to be merit in some focus on the health team approach, even in terms of development of the knowledge base.

The move can, of course, be justified on patient-centered grounds and usually is. But my concern here is its likely effect on the development of nursing as a discipline. While it could be argued that nursing needs to get its own house in order (firmly establish its theoretical base) before it can contribute equally in a health team

approach, I am more inclined to see the knowledge base being enhanced by collegial interaction as suggested above.

The health team approach, however, does seem to demand an acknowledgment that health professionals share a common body of knowledge which they learn in different ways and approach from different perspectives, as well as their own particular knowledge which tends to merge with it (as knowledge tends to do). The most accurate designation of this common body of knowledge is medicine, but this is unfortunately seen as the preserve of one particular group of health care professionals, even though it was not developed exclusively by them (nor is being so developed today). The health team approach, therefore, seems to require a distinction between the body of knowledge and one particular approach to its use.

The Management Function

As competency 7 of NRB guidelines relates to the management of professional practice, it is little surprise that the managerial role of the nurse received some attention in the description of nursing. Terms used were manager, decision maker, problem solver, group leader, and change agent.

The relevant competency reads that the graduate should be able to:

> Participate in the development, organization and evaluation of a milieu which will complement a variety of modes of nursing practice.
> (NRB, 1984, p. 6)

The more detailed spelling out of this includes application of

principles of management to clinical practice, leadership, planning and provision of nursing care, assessment and evaluation of nursing care, and an understanding of research methodology. Since the provision of individual care was covered under previous competencies, the organization of nursing care in this competency obviously refers to the multi-patient situation, an area which has been identified as a problem for new graduates in the U.S. literature (see, for example, Kramer, 1974; Benner & Benner, 1979).

The same literature reports the leadership role as problematic for the new graduate in terms of learning to delegate and to supervise others (including older workers) (Benner, 1974). But it is by no means clear that the teaching of the sort of material detailed above would provide the new graduate with competency in the managerial function understood in this way. They are the sort of skills that were learned on the job, as part of the paid workforce, in the previous apprenticeship-type training system. The previous curriculum had thus devoted only 10 hours to an area called Principles of Unit Management (NRB, 1976), the content of which is very similar to the detail under this competency.

It is clear that there are managerial skills used by nurses at the level of clinical practice that could reasonably be regarded as part of the nursing knowledge base, but which are not encompassed by formal theories of nursing with their focus on the nurse-patient dyad. In addition to formal knowledge input suggested by this competency, they include skills like the setting of priorities, dovetailing of work to cope with multi-patient situations, and handling of relations

with experienced (often older) auxiliary staff who work under RN supervision, as well as handling relationships with other health care professionals.

Considering simply the organization of work, to the extent that a nursing model is adopted as the rationale for curriculum organization, these areas will be left "out in the cold" and have to be tacked on in some way. This can be clearly illustrated by looking at a recent curriculum re-write which uses nursing diagnosis as its organizer. While units 1-7 are organized around nursing diagnosis (perceiving, feeling, knowing, exchanging, etc.), unit 8 does not use one of these themes, but picks up the sort of material suggested under competency 7 (NRCAE, 1988, pp. 114-117). Similar problems can be seen in the other curriculum documents, this sort of material sitting uncomfortably whatever the framework chosen. While such material appears in detailed course content, it cannot readily be seen as flowing from the model.

In line with the work of Benner and Benner (1979), one can also ask questions about the extent to which formal knowledge can assist with the achievement of competency in management of professional practice. While formal knowledge may be useful, it does not seem to be sufficient because of the highly contextual and experiential nature of the skills involved. Benner and Benner (1979) suggest the need for sponsorship of the new graduates, so that they can work with someone experienced in managing the exigencies of everyday clinical practice. This would place the development of this competency in the post-graduation period, rather than competence <u>at</u> graduation as the

NRB guidelines require. The question then becomes how to develop at least beginning competence in this area.

The solution I found most appealing in these documents was the one adopted by Kuring-gai CAE, where a unit on nursing within the bureaucracy of a health care organization was followed by a "work experience" clinical in nonspecialized wards of general hospitals. The intent of this placement was that students learn from experience, the rationale being set out as follows:

> During the placement students will be provided with opportunities to acquire knowledge by experience. By this is meant knowledge based on the participant's experience that she/he can do specific things, for example, knowledge based on experience that she/he, as a nurse, can function as a member of a ward based health team in assisting patients meet their self-care requirements ... knowledge based on experience that she/he, as a nurse can take corrective action if activities that have been initiated do not turn out as expected. (KCAE, 1984, p. 163)

It was thus intended that, close to the end of this course, students be given a chance to "try thesmelves out" while still under the protective aegis of student status. This curriculum thus recognizes the experiential nature of management of professional practice.

Although less clearly recognized in other documents, some such thinking may have underlain the inclusion of clinical electives in the last semester of most programs. (Kuring-gai had a clinical elective in addition to the above which was explicitly linked to it.) In the program of which I have firsthand knowledge, the clinical elective has been handled by "buddying" students with willing RNs in an area of student choice. The student is "rostered" on the same shifts as the

RN and works at all times with her, with college personnel playing only a background support role. This final period of clinical experience thus provides a supportive introduction to workforce realities in addition to its ostensible purpose of allowing students to increase their knowledge, understanding, and experience in an area of their choice. While I am less familiar with the arrangements of other colleges, their clinical electives seem to be functioning in a reasonably similar fashion.

It is probably relevant to add that school-to-work transition programs have been funded in NSW by the Health Department that vary in organization from institution to institution (and which are changing in response to experience). The overall RN shortage (which makes it highly desirable to attract college graduates) has imparted a competitive edge to such programs, since reports of their usefulness circulate informally around the student "grapevine."

Perhaps for these reasons (and others) there has been surprisingly little criticism of the new graduates, the greatest cause for concern centering around their lack of familiarity with pills and potions, which is not central to the issues being discussed here.

This area is a particularly clear example of both the inadequacy of a single theory approach to nursing knowledge and the accompanying inadequacy of an approach that sees nursing knowledge for the curriculum unfolding in linear fashion from the adoption of a nursing model for the curriculum. At least as currently constituted, nursing models provide no way of encompassing the move from the single patient/client to the multi-patient/client situation, which is the

reality of most nurses' working lives. (Where groups are dealt with in nursing theory, they are cohesive groups that really just substitute for the individual in the theory.)

To the extent that nursing knowledge is taught in such individually-focused terms, an important area of practice knowledge will therefore be neglected. Some complaints about the gap between theory and practice can be understood in this light. While such knowledge, like nursing knowledge more generally, would run up against the limits of formalization, it lacks even a legitimating framework as the theories currently stand.

This issue does, however, arise as a theme in Benner's exemplars and in her account of skill acquisition. The novice or advanced beginner is described by one respondent as being "like mules between two piles of hay" (Benner, 1982, p. 404), when faced with conflicting demands on their attention. While really expert organization can only be developed in the context of considerable experience, it seems reasonable to point to the lack of formal development in the area which would provide beginners with something to go on. Compared to the enormous literature focused on the individual patient-nurse relationship, there has been very little examination of nursing in the multiple patient context.

CHAPTER XII

CONCLUSION

As I have argued, curriculum development in NSW, as in the USA, was seen predominantly as a means toward the explication of nursing knowledge, sometimes expressed as the development of the discipline or science of nursing (although the terms are not equivalent, discipline being the broader category). More generally, they can be regarded as developing a distinctly nursing discourse. Seeing it as a discourse which has been developing a distinct public voice retains its continuity with the past (its history) and its ongoingness. An occupation which has been backgrounded by the culture's focus on technological cure is now struggling to make its voice heard in the public arena.

As nursing has set about deliberately developing its own discourse, it has done so by distinguishing itself as sharply as possible from medicine, castigated as "the disease model" in contrast to nursing's "health model." Yet the connection with medicine remains, characterized by Henderson (1960) as dependent practice and more recently by Carpenito (1987) as collaborative practice. The teaching of medicine was very evident at the level of content in the NSW documents, however "covered over" in philosophical statements.

In order to sharpen the distinction, nursing has reified medicine, making of it something of a straw-man. However, medicine, too, needs to be seen as a developing discourse. Although its main ontological thrust remains the diagnosis and treatment of disease (a

normalization model), the medical discourse has been coming up against its limitations which are bringing about modifications of its discourse. These modifications are most clearly seen in areas like general practice (where most patients do not have a diagnosable disease), oncology, rehabilitation, geriatrics and, more recently, the treatment of people with AIDS. It seems that it is in these sort of areas that nurses have been able to develop most powerfully their collaborative role, bound together with doctors and other health professionals in common cares and concerns. (This assumes the presence of nurses who have learned to value their own contribution and doctors and other health professionals who have a progressive approach to their field.)

If nurses are able to accept that medicine is also a legitimate part of their knowledge base (a crucial part of their discourse), the development of the collaborative role can aid the further modification of the medical discourse in desirable ways, important for the sake of the cared for, but also enriching to the nursing discourse.

Centrally, nursing has come to consider itself as concerned with illness rather than disease, understanding illness as the disturbance of our ability to function smoothly in the world. It has also seen itself as concerned with care rather than cure, suggesting that illness is best dealt with through a caring approach aimed at prevention of deterioration and/or restoration of optimal functioning. To the extent this division is accepted, the process of healing continues to be divided into care and cure, simplifying a much more complex process. There is some recognition of this in some of the NSW

documents that see nursing as involving both.

Although the concern with illness is increasingly expressed in terms of health (as in the NSW documents), health tends to be seen in terms of optimal functioning in the world, rather than in terms of absence of disease. Thus, the discourse about health is coherent with the discourse about illness. The discourse about health also seems to involve the idea of health as a sense of well-being, harmony and coherence, as identified by Benner and Wrubel (1989), which is perhaps an elaboration of the old nursing precept to "make the patient comfortable." In this way Martha Rogers' (1970) definition of nursing as the promotion of symphonic interaction between man (sic) and his environment makes sense. It makes sense also of a phrase used by two of the NSW documents--"healthy death"--which otherwise seems like absurdity (in terms of optimal functioning or disease models).

Nursing has thus been self-consciously moving away from the language of disease and disease models which dominated its discourse during the time it was seen as an auxiliary service, supportive to doctors. (This is not to suggest the complete absence of a sotto voce alternative discourse during that time.) The extent to which this discourse remains independent of medicine depends on the way medical discourse itself develops which, in turn, interacts with changing patterns of discourse in the wider society, e.g., the incorporation of ideas from "holistic" health movements. In other words, it seems to be altogether possible that nursing could find much of the discourse it is developing again subsumed within medicine, with both positive and negative consequences. The discourse of medicine would be greatly

enriched, but the claims for an independent nursing discourse undermined. (Sullivan, 1986, argues for expanding the discourse of medicine to include illness.)

Yet it seems clear that nursing in its practice sets up a different world to that of the practice of doctoring, grounded in the existential reality of being with the patient on a more continuous, rather than intermittent basis. While it is clearly possible for doctors to sometimes function on a continuous basis and nurses on an intermittent one (as in domiciliary care and consultative practice), the general thrust of nursing preparation and practice is toward a continuous presencing and that of doctors toward an intermittent, though continuous, one (true also of other health professionals).

Continuous presencing sets up a world of attention to the particularities of the patient's cares and concerns. As nurses continue to insist, continuous presencing means that they get to know the patient better, to understand them better. Given the human experience that understanding of this type is highly likely to engage our cares and concerns, it is not surprising that nursing continues to insist on the importance of care to its practice beyond the old sense of physical care (see Chapter IV). Thus, the NSW documents examined here strongly emphasize nursing as caring.

It is not surprising that this strongly developed sense of what nursing is about has proved very resistant to being spelled out in logico-positivist frameworks. Indeed, it can be argued that such frameworks can only exist against a background of a world of care where others weave the fragmented parts together. As I have argued

(Chapter V), reduction of caring to context-free variables destroys its meaning. Many theoretical developments in nursing can be broadly understood as attempts to capture caring in logico-empiricist terms.

Nevertheless, the endeavour to explicate nursing in this way has made visible some aspects of the practice and, in doing so has, to varying extents, re-shaped the practice. More important than any particular nursing theory or model has been their general contribution to the development of the belief that nursing is worth talking about in the public world, i.e., that it is a legitimate discourse. While people other than nurses are less aware of this, the development of the discourse within nursing is now impacting more on institutions closely associated with it.

But the contribution of nursing theorists has also been more specific than this because they have developed ideas that have now become part of the discourse. Thus, the NSW documents considered here use the language of "meeting needs" and "making up self-care deficits," not always attributing those ideas to Henderson and Orem respectively. As the need for such attribution attenuates, the terms become part of the language, their origins of interest only to the historian of nursing ideas (as in sociology would be the first coining of the term socialization). But to remain alive, they require continuing exploration (like the term socialization).

Similarly, Orlando (1961) found it necessary at the time to distinguish deliberative from automatic nursing care, making visible the decision-making processes of nurses, constituting them as an appropriate subject for discourse. In this discourse, we can see the

origins of the nursing process, and, more recently, nursing diagnoses. In spite of the problems of these approaches (which seem to arise from their lack of fit with the existential reality of nursing), they have had the effect of making more visible to nurses themselves their active decision-making. Some of the NSW documents (like some of the nursing literature) show a desire to move beyond what has become a reified nursing process framework, reflecting its re-constitution as an active area of the discourse.

It is possible, similarly, to see how other ideas coming out of the work of nursing theorists have made visible other aspects of nursing practice and thus helped to re-shape that practice in particular ways. However, what the nursing theorists did not succeed in doing was to provide a universalistic account of nursing, but I doubt whether any discipline has succeeded in developing such an account (Emden, 1988).

Where nursing theory seems to have gone most astray is in not sufficiently listening to the discomforts (protests, even) arising from those situated in the existential experience about the frameworks being imposed on them. While the langauge of "pure types" will always fail to mesh with the existential situation, nursing has tended to fail to recognize this and to impose its "pure types" as prescription for practice. This seems to relate to a desire to shape nursing as a neat package of knowledge and skills which, I would argue, is connected with the close tie between curriculum development and theory development. Underlying it one can see elements of the old "procedure manual" approach to nursing.

As I see it, there has been an attempt to force-feed nursing's development through formal means rather than through the encouragement of the emergence of a discourse. I would see the later as much more multi-faceted and open to dialogue with the existential reality of practice. Universalistic nursing theories, the nursing process, and a single taxonomic approach to nursing diagnosis can be seen as part of the force-feeding effort. (In addition, the NANDA approach to nursing diagnosis appears to be informed by a monolithic, excessively rational and universal account of medical diagnosis which does not stand up to critical examination.)

Nursing is different but it is not unique, except in the sense that every occupation is unique. Emphasizing the uniqueness (which has been part of the quest for its own body of knowledge) leads to an overlooking of useful continuities that can enrich understanding. There is, as I have argued, continuity with the traditional unpaid caring of women from which nursing has turned its face (because "unskilled" and unpaid). Yet nurses, and the health care system more generally, continue to rely on it for without it the whole enterprise of health care would become unmanageable. Nursing's visibility is thus bought at the cost of the remaining invisibility of the wider work of care which makes it possible. Because of this continuity, caring becomes an embarrassment (Benner, 1989), and efforts are made to show that nursing is different because scientific--if necessary, by scientizing caring itself.

Yet a recognition of the continuity can revivify the discourse of caring within nursing in interaction with the explorations of the

feminist movement. Within nursing, the work of Benner (1984) has revivified the discourse of caring by demonstrating the inadequacy of the dominant ontological base to encompass skilled nursing practice. Outside nursing, feminists have been exploring and critiquing that same ontological base as patriarchal through and through and totally inadequate to the exploration of women's being-in-the-world.

Thus, while previous attempts to vivify the discourse of caring took place within the dominant ontology (e.g., Watson, Leininger), the possibility is now opened up for its exploration within an emerging ontology. In its Heideggerrian form, the emerging ontology seeks to address the increasingly apparent limits of the old ontology which has given rise to an extreme form of technological understanding where self, other, and world are objects to be shaped to man's desire. In its feminist form, it seeks to address and redress the invisibility of women's being-in-the-world (including their work in the world). The two come together most clearly in addressing environmental concerns.

Yet the world of medicine is patently still part of the old ontology, indeed a crucial part of it, making it difficult for nurses to change their way of thinking, at least at the level of their public discourse. The old ontology has been a powerful one and has a strong hold upon us. Medicine also remains the power discourse in health care, established as such ontologically, ideologically, and politically. Although the degree to which it is a science can be queried, the common belief that it is such increases the power of its discourse in a society that largely accepts the authority of science, science thus becoming a powerful legitimating ideology.

Thus the attempt to set up nursing discourse as a science is very understandable, although it has been frustrated by nursing's insistence on maintaining the caring connection, as I have argued. This can be seen as a refusal to background caring, as other occupational groups have done, for the sake of neatness of fit with the dominant mode of discourse.

The emphasis on illness rather than disease suggests the importance of a lived-experience approach to understanding human beings, but this approach is, as yet, poorly developed in the nursing literature. Only one of the original 1984 documents in NSW seriously addressed lived experience, although the 1987 Armidale revision also does so. The recognition of lack of nursing literature in the area prompted Kuring-gai College to use fictional accounts and Armidale to attempt an ambitious drawing together of extant literature from a range of disciplines. But the documents on the whole suggest that this is only starting to be problematized as part of the discourse, although it flows fairly naturally from positions of health and illness in the nursing literature. In its absence, there is a tendency to slip back into the disease model. The work of Benner and Wrubel (1989) can be seen as starting to make visible the sort of discourse which could develop quite powerfully in this area.

The concern with illness also has the potential for developing a powerful moral discourse centered around the patients' cares and concerns, rather than patients' rights. While present in the practice, it has been less visible in the formal discourse. As Packard and Ferrara (1988) argue,

> The idea of nursing requires careful and continuous illumination that the moral practice of nursing can be intelligibly discerned. (pp. 70-71)

Once nursing moved beyond seeing professional ethics in terms of deference to the doctor, it was faced with a gap between formal ethical codes and theories and existential situations of practice which was bridged with the discussion of ethical dilemmas. But, as Packard and Ferrara suggest, this tends to "cover over" the more general moral practice of nursing, focusing the spotlight on common areas of debate in the health care field. Thus, nursing ethics tends to become bio-ethics.

While bio-ethical dilemmas continue to need discussion, there is a less visible form of moral discourse in nursing which has been difficult to abstract from discussions of the knowledge base. As Stevens (1979) points out, nursing theories are value-laden in a strong sense. It has proved difficult, if not impossible, to develop a purely descriptive theory of nursing (or something that looks like one). This contrasts with the apparent value-free structure that medicine has been able to develop (which covers over its value system).

The close tie between knowledge explication and curriculum development explored here may have accentuated this. But it also suggests difficulties with scientization of caring invoked with even attempting to abstract it from moral discourse. To do so would be to constitute nursing much more like our common understanding of cure. While nursing has been prepared to accept that good care can be curative, it has been reluctant to see its role purely in terms of

cure, although current moves to standardize nursing diagnoses and treatments can be seen as likely to lead in this direction, which may again open up a caring "gap" as I have suggested.

Discourses, as Foucault has argued, have been powerful in constituting human beings and the world as objects of control. In using the term "discourse" in relation to nursing, I must recognize this. Yet there may be a possibility of constituting a different type of discourse which is incipiently there within the nursing literature and which is now being spoken of in terms of empowerment. A discourse about caring in its emergent sense seems to demand this, if only to avoid the newly identified "disease" of co-dependency.

Caring constituted as a power discourse in Foucault's sense would take over and subsume the recipient of care. Caring has that possibility within it, particularly as those who provide care move from their traditional patterns of subservience, i.e., as they begin to experience themselves as powerful. There is a tendency to conform with the dominant notions about power in the society. Yet there have also been signs in nursing of an alternative conception which tests the efficacy of caring practices by the empowerment they provide to recipients of care. A lot of discussion of the nurse as patient advocate seems to involve this issue, as does the concern for understanding the patient's experience. Nursing theories of the needs/deficit variety have built into them a concern about the sort of care that takes over, which is also strong in the interaction theories. At issue seems to be the moral control of care and its shaping toward what is now being identified as empowerment. But,

again, the notion of an empowering discourse sits uncomfortably with the encompassing traditions of knowledge, although there are dissident voices within the human sciences that are also moving in these directions (here, for example, Richardson's [1988] account of the liberation narrative within sociology--and, indeed, Marx also told a liberation narrative).

If we consider nursing as a discourse, the strands within it are very complex and intertwined, as I have illustrated. Considering it as discourse seems to open up new possibilities, but it certainly provides no easy answers for the structuring of its knowledge base, nor the process which has so far been intertwined with it--that of curriculum development. But simple answers have proved very elusive, as I have argued.

Perhaps it is time to jettison the metaphoric procedure manual, as we earlier threw out the literal one. This would involve the recognition that we are not alone in having a discipline which is complex and multi-faceted, which overlaps with other disciplines but which is shaped by its practical interests that in turn are shaped by its cares and concerns. This is not a recipe for anarchy, but a recognition that the practical world of nursing, which has proved its resistance to formalization, is strong enough to provide whatever ordering is necessary.

This is not to suggest that the world of practice alone holds the answers--rather that it is an important source of the questions we need to explore, not just in the limited sense of researching clinical questions, but also in the sense of creating a greater degree of

self-understanding for that practice so that it escapes from trivialization and invisibility.

As I have argued, nursing has been grappling and continues to grapple with issues which are central to many of the problems now coming into view as limitations of the ontological view adopted in Western society which has marginalized alternative ways of situating ourselves in the world. Because of its origins in a predominantly female world, in particular, consideration of nursing makes visible many of the issues that women face as they seek to retain connection with traditional values but move into a public world structured around other priorities.

This study has been directed toward achievement of a greater degree of self-understanding for nursing and for nurses, in the faith that such self-understanding is emancipatory, as Habermas (1972) suggests. To the degree it is emancipatory, it opens up possibilities of exploring different ways of acting in the world, arising out of a different "take" on the world. But such self-understanding (or lucidity) is never complete, holding within it the needs of future and possibly better understandings, and thus the journey continues.

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Appendix A

Words and Phrases Used

These lists are adapted from those compiled in the early part of the research to provide a general overall picture. They were compiled by listing what seemed to be key words and phrases used to express central ideas. Multiple terminology was used, so numbers do not sum to n = 19.

At the level of analysis, I went back to the documents to read the usage in context and to gauge their importance to the curriculum model.

Human Beings--Man/Woman/Individual/Person

Bio-psycho social	9	
+ cultural	2	
+ spiritual	5	
+ emotional	2	
More than sum of parts	5	1 lived body, lived self 1 part of a greater whole 3 vague
Self-care agent	4	
Possessor of needs	5	
On developmental continuum	9	
Systems/Adaptation	2	
Healthy death	3	

Society

Family	6
Community	6
Cultural groups	4
Social network	2
Groups	4
Nation	5
World	2
Industry	1
Social systems & institutions	2

Environment

General mention	8
Health environment	3
Bio-physical and psycho-social	1
Socio-cultural	1

Appendix A (continued)

Health

General	3	
Wellness	3	
Dynamic state	4	
Homeostasis	3	
Adaptive response	8	
Optimal functioning	7	
Personal perception	3	
Relative normality	3	
Holistic functioning	1	
Lifestyle	1	
Ability to perform activities of daily living	1	
Health-illness continuum	9	
Interaction of health and illness	3	
Peaceful and dignified death	2	
Illness	6	
Health deviation	3	
Health breakdown	3	
Disease	4	
Disability	2	
Dysfunction	1	
Pain and suffering	1	
Health needs	1	

Nursing

Interpersonal process	9	
Clinical practice discipline	1	
Application of health-care	1	
Applied science	1	(also both art and science)
Developing discipline	1	
Moral activity	1	

Caring

Caring/holistic care	14	
Self-care deficits/ Activities of daily living	6	
Meeting needs	3	
Protector, healer, comforter	1	
Compassion	1	
Supportive/assistive	1	
Total patient care	1	
Individualized care	2	

Appendix A (continued)

Caring (continued)

Therapist	5
Dependent/Independent functions	3

Teacher/Counsellor

Health promotion	7
Teacher	8
Guide	2
Development facilitator	2
Assist with identification of health goals	2
Counsellor	1
Mutual teaching in dialogue	1
Communicator	5
Health care facilitator	

Management

Manager	3
Change-agent	2
Decision-maker	2
Problem-solver	5
Group-leader	1
Researcher	3

Health Maintenance/Promotion

Preventive	8
Promotive	7
Habilitation/Rehabilitation	6
Maximize quality of life	1

Appendix B

NSW Documents Cited

NSW Institutions Originating Documents	Document Identification
Armidale College of Advanced Education	ACAE 1984 ACAE 1985 ACAE 1987
Avondale College of Advanced Education	Av. CAE 1984
Catholic College of Advanced Education	CCAE 1984
Cumberland College of Health Sciences	CCHS 1984
Hawkesbury Agricultural College	HAC 1984
Kuring-gai College of Advanced Education	KCAE 198
Macarthur Institute of Higher Education	MIHE 1984
Mitchell College of Advanced Education	CMAE 1984
Nepean College of Advanced Education	Nep CAE 1984
NSW Institute of Technology	NSWIT 1984
Newcastle College of Advanced Education	NCAE 1984
Northern Rivers College of Advanced Education	NRCAE 1984 NRCAE 1988
Riverina College of Advanced Education	RCAE 1984
Sydney College of Advanced Education	SCAE 1984
Illawarra Regional Council of Nurse Education in conjunction with Institute of Advanced Education, University of Wollongong	U of W 1983
Institute of Advanced Education University of Wollongong	U of W 1986

Appendix B (continued)

Other Documents Cited

NSW Higher Education Board--Basic Nurse Education: Guidelines for Advanced Education Institutions in the Preparation of Documents. March 1984 (abbreviated to HEB 1984).

NSW Nurses Registration Board--Basic Nursing Education--undated, but early 1984 (abbreviated to NRB 1984).

State Planning Group Bulletins (SPG).

Accreditation Committee Reports

Armidale CAE 1984
1985

Northern Rivers CAE 1984

Letter-Principal, Armidale CAE to Chairman, ACAE Accreditation Committee, September 1984.

Letter--Dunlop to Colleagues, September 1984.