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Beginning Journeys - Volume 2

Developmental Concepts: Stress

Wayne Ross, Bachelor of Nursing Student

Driving home from work, or perhaps from polytechnic after a hard day, traffic lights turning red, the car petrol gauge on empty, running late for your next appointment - so much pressure! Many people would say these types of situations can cause intense stress. What then is stress? Why study it? Stress can be defined as "the body's response to any demand on it" (Papalia & Olds, 1989, p. 500).

Accepting this definition alone seems reason enough for studying stress. Every time we think or move we are experiencing some degree of stress, in fact, by merely existing we are subject to stress. A term to describe the general cause of stress is "stressor". This can be defined as, "an event capable of producing stress, although not necessarily doing so" (Papalia & Olds, 1989, p. 502).

This definition shows that the cause of stress in one situation is not accepted as a universal stressor. A general example would be the differing degree of stress, if any, that different people experience when exposed to the same stressor. Why is this? Why is our ability to deal with stress as unique as our personality? This is but one angle to consider as we examine stress in regards to the two stages - childhood and adulthood. Interviews are recorded with a person from each of these developmental stages though their names have been changed to respect their anonymity.

Childhood

From the time of conception, until we die, we continually endure differing degrees of stress. Normal childhood stress takes on many forms. Illness could be considered a cause and a symptom of serious childhood stress. The effects of illness also have the potential for affecting the normal healthy emotional development of the child. Events which have an impact on contacts and interactions with family and significant other people can have serious consequences.

Changes in geographic location, introduction of new family members, physical or sexual abuse, poverty and many more serious stressors also open the door to a whole string of further pressures. An example would be the major adjustments a child would face when relocating to a new home situation; new friends at a new school, new teachers and new and different routines.

The extent of the consequences of such changes would depend on factors such as the initial stressor or event, the age of the child and the child's sex (research shows that boys are more vulnerable to stress than girls). A child's academic proficiency also seems to have a bearing on their adaptive responses to stress, although it is not clear why. Perhaps the high self esteem exhibited by children noted as "achievers" helps them to cope better; maybe these children are better at solving everyday problems in life as well as in their schoolwork.

Other areas which seem significant, though there is little research to support this are inherited differences in capacity to handle stress; the effect of difference in character which seems at least partially determined by genetics (Papalia & Olds, 1991).

Expressions of stress felt by children may be the result of conscious or unconscious responses. Many children use unconscious coping responses, copying their parents and other adults without even realising it. Others conform to peer pressure as they cope with stress - by smoking, drug use, violence or intimidating others. Reacting in ways you have chosen because they work and you are aware of what you are doing, means you are coping intentionally and consciously. It is therefore important to develop appropriate conscious behaviour patterns to deal with stress as children (Schafer 1978).

Jamie, a seven year old boy was separated from both parents for two years - from two years six months until he was four years six months old. His mother describes the effect of this separation as "devastating." He spent his time moving between various foster homes and being shuffled around the homes of relatives. All this happened with minimal contact with his parents.

Previously a boisterous, outgoing and lively boy, Jamie returned to his parents as a withdrawn lad with no self confidence or self esteem. He suffered from chronic bedwetting.

When faced with any pressure or stress, Jamie reacted with either destructive behaviour or frustration and tears. After three years of living in a stable environment and being given what his mother calls "large doses of unconditional love" Jamie has shown a big improvement.

However Jamie's mother considers there has been permanent damage to her son's ability to cope with stress. In this one area he still gives in to frustration and tears when he feels he can not do simple tasks. His frequent personal defence when he faces these problems is the often repeated phrase, "I just can't do it".

It would seem Jamie's coping response to stress is to adopt an attitude of failure - to quit and so cut off any

more stress. His mother is considering counselling for Jamie.

Adulthood

Conscious or unconscious coping responses to stress are as common to adults as they are to children. Whether a coping response is harmful depends on the person and the situation. However, it is possible to identify responses which are usually destructive - that lead to ill-health, interrupt personal development or affect others. Some examples are, "drinking too much, smoking, violence, heavy drug use, overworking, eating too much, staying up too late, procrastination, compulsive spending, total withdrawal" (Schafer, 1978, p. 163).

Over a period of time from childhood to adulthood, habits or patterns of responding to stressors are developed. Usually adult responses are appropriate and useful - reactions which make "sense" and remain within moderate and acceptable boundaries.

Distress

Sometimes however adult behaviours may fall outside of acceptable boundaries and may even become self destructive or destructive to others. This is a clear sign of stress overload or "distress".

Distress is intense stress involving,

1. damaging wear and tear on mind and body
2. serious interference with daily life
3. destructive behaviour towards others (Schafer, 1978, p. 55).

Distress may display itself in any of the following forms; physical, emotional, intellectual or behavioural.

During the interviews conducted with Bob, a 26 year old man, details of his stress, and its management verged on distress. He complained of regular incidences of irrational reactions to stressful events, stating that he felt out of control and powerless to calm himself, even when he was conscious that situations were getting out of hand. Bob noted that he first became aware of the "inappropriate" reactions to stress developing as a teenager, about the time he left home and went flatting.

He felt that without the presence of dominant parents he would be free to express more anger, and as work pressures built up this sort of expression became more concentrated when he felt stress. Bob had come to the point where he broke belongings and expressed aggression towards others whom he felt had caused his stress. He is now quite aware that he has manifested his responses to stress in an unhealthy manner and he is working to change his behaviour towards more passive stress management - recognising that stress is a "natural" part of life.

Conclusion

Both the examples provided by Jamie and Bob reflect stress at the more extreme end of the scale. However, luckily in both situations, appropriate steps are being taken to modify stress responses.

In Jamie's case he suffered high levels of stress during a crucial developmental stage in which Erikson claims "self is first felt and developed" (Papalia & Olds, 1991). More stress is caused through having low self esteem because of feelings of inadequacy.

In Bob's case, development of his stress responses seem to have been retarded due to dominant parents exerting pressures which inhibited healthy behaviour.

Regardless of the circumstances causing a deficit in the ability to deal with stress, it is possible to address problem areas and attempt to modify or relearn more appropriate responses.

All living creatures suffer stress in one form or other. For the human being, a balanced healthy and caring environment is a good foundation for dealing with a lifetime of stress. With differing foundations we therefore grow up with differing abilities to manage stress.

References

Papalia, D., & Olds, S. (1991). Lifespan Development. Sydney: McGraw Hill Book Company.

Schafer, W. (1978). Stress, Distress and Growth. California: International Dialogue Press.

Acknowledgements

Bob (Personal communication, 1995).
Jamie (Personal communication, 1995).

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Reality Versus Rhetoric

Linda O'Donovan-Pinker, Bachelor of Nursing Student

Introduction

"Shortland Street"and "ER" are two popular television programmes shown to New Zealand audiences which portray the nursing profession. Both programmes I believe give glimpses of the reality of our profession, enabling the viewer to have a window into the world of the nurse. However because of the need to present fast-paced, adrenalin inducing drama such as "ER" important details can be overlooked. In the case of "Shortland Street" it would appear to me that medical technique is never allowed to get in the way of a good gossip between nurses.

I will compare and contrast how these programmes display the client-nurse relationship, and how the nurse relates to other health professionals. I believe sometimes these programmes can be an ally for the nursing profession through educating the public about the social and lifestyle factors that contribute to our health.

In view of this I believe it is important to ascertain whether this information is accurate, considering the viewer may be unable to distinguish between entertainment and fact. Finally I will speculate on how I believe these programmes contribute to the image of nursing in New Zealand.

Location

"Shortland Street" is set in a medical centre that encompasses a wide variety of departments; everything from Accident and Emergency to plastic surgery, General Practitioners and physiotherapy, counselling from a social worker and a sophisticated High Dependency Unit. Here the nurse is to be versatile enough to appear in every department. No particular expertise is apparently needed. When there is a lack of staff at reception a nurse is always commandeered without protest.

"ER" is an emergency department in a city in the United States. Here the emphasis seems to be placed on the skills of the doctors. Storylines hardly ever revolve around nurses with the exception of the charge nurse. However I am tempted to think this is because of her relationship with the department's Paediatrician. Most of the time I notice, nurses are shown chasing patients on trolleys while performing C.P.R., chasing doctors to sign prescriptions and generally running about following instructions from the physicians. A certain value is given to the competency of the charge nurse. She is hardly ever ordered about and is seen to anticipate the needs of the patient.

Roles

If I relied on these two programmes to help me decide if I wanted to be a nurse I would have chosen an alternative career. The nurse's role too often falls into the stereotype. In Shortland Street the Director of Nursing regularly uses her position to manipulate her colleagues. Most of the nurses perform the "handmaiden to the physician" role. However at times welcome alternative roles have been displayed, e.g. nurse as patient advocate. An intellectually disabled woman was admitted and found to be pregnant. A nurse was shown spending time with the patient, listening and assessing her needs holistically. The patient's mother wanted an abortion performed without consent. After a psychiatric report the doctor supported the decision for an abortion without even talking with the patient. The nurse was shown to stand up for the rights of the patient.

In another episode the nurse is shown arguing with the doctor. She says, "I stand up for my patients, if you don't like it, tough." However the manager of the clinic disciplines the nurse after a complaint from the doctor and the role of patient advocate passes over to the clinic's social worker. He proves to be more effective mainly because the manager and doctor value what he says. I suspect the fact that he is male contributes to his effectiveness. The regular censuring of nurses on Shortland Street I believe, keeps them in a submissive role.

ER endeavours to show the full horror of an emergency department, sometimes sacrificing reality. Even though I have been a student nurse for only a short time I have already experienced a patient/client looking to me or a registered nurse for reassurance or information. One situation on ER involved a pregnant woman shot in the abdomen. She is rushed from the ambulance to the emergency room, accompanied by nurses. She is crying and shouting for help. Not one of the nurses even holds her hand or speaks to her. I felt that her unacknowledged anguish was ignored to add suspense and drama at the expense of reality. I sometimes become quite frustrated with the role of nurses as displayed on ER. A doctor will enter the room and the nurse hands him/her notes or gloves or often quietly slips away as though she no longer has a valid function. The only nurse who is shown to have a positive role is the charge nurse. She is presented (I believe) as an important part of the health team.

Relationships with Clients and Colleagues

Nurses in Shortland Street have very good relationships with their clients, mainly because most of their clients are friends, family members and colleagues. Sometimes a nurses becomes a client. A stereotype given to the nurse is one of constantly trying to attract a doctor. One nurse was shown to have shortened her uniform in the hope that a doctor would view her with sexual interest. I consider this attitude would be a major impediment to the doctor valuing this nurse on a professional basis. On Shortland Street the nurse/client relationship gives the impression that the client looks to the nurse to tidy up after them. If the client wants information or a change in treatment they ask to see the doctor. The nurse is not seen as an integral part of the process but merely a cog in the wheel.

As previously mentioned the charge nurse on ER is the nurse who appears to have the most professional respect from her colleagues. She is regularly seen to display a variety of skills including counselling, I.V. installation, C.P.R. and staff management. However she is known to have had personal relationships with two doctors and her capacity to cope with the pressures of the job is questionable because in one series she made a suicide attempt. A small amount of animosity was shown between doctors and nurses in the last series due to doctors not signing prescriptions and nurses taking some of the blame from management. Particularly in this situation we saw an unbalanced professional relationship between doctor and nurse. Doctors were shown to have ultimate control in the dispute.

Health Issues and Contributing Factors

I have watched Shortland Street for two years and in that period many health issues have been incorporated into the series. Stress-related heart disease, tetanus, Legionnaire's disease and breast cancer to name a few. Recently a character who worked in a gym contracted Legionnaire's disease and had difficulty recovering because he had been taking steroids for body-building. This storyline demonstrates to me that Shortland Street takes its popularity among young people very seriously. It clearly outlined the factors that contributed to this health issue. Steroid abuse and insufficient monitoring of the gym's air-conditioning system resulted in a young, strong and healthy man almost losing his life. Another character developed tetanus because he failed to have regular immunisations. A character currently has breast cancer and she is shown to exercise regularly, eat a balanced diet and practise relaxation techniques. But Shortland Street does not offer the distorted view that fighting cancer is easy, it is careful to show that the character experiences nausea, fear, depression and fatigue.

In contrast, ER does not seek to warn us of the effects lifestyle and social habits have on our health. Its main objective is to excite and disturb its audience. It does not adopt a preachy tone like Shortland Street. In my view it focuses more on the shock value of being in an emergency room in a violent United States city. There is some comic relief for the audience but this is usually cut short by the arrival of another gun shot victim.

Contribution to the Image of Nursing in New Zealand

ER positively contributes to the image of nursing to a certain degree. Nurses are shown to have a certain level of competence and at times they are shown to talk quietly with a patient amid their high pressured working environment. However running around after the doctors tends to perpetuate the "handmaiden" myth.

Shortland Street will often frustrate me because it sometimes appears to gather all the negative images of nurses and put them in one scene. The short-skirted nurse will argue with and abuse the manipulative Director of Nursing in front of patients in reception. Nurses spend a lot of time chatting, while they should perhaps be with a patient. Hospital romance is given more focus than patient's needs. Every week nurses behave in what I consider an unprofessional manner. Yet I will continue to watch this programme because despite its poor image of nursing I enjoy its humour and benefit from its demonstration of a variety of cultural beliefs and values.

Both these programmes aim to be entertaining. Each one displays the role and image of a nurse differently. Reality is not often allowed to intrude into the scenes portrayed. The sometimes unpleasant aspects of nursing are kept hidden. I can only speculate on the amount of damage these programmes do to the image of nursing but I am inclined to believe the New Zealand audience can separate fact from fiction most of the time. Although Shortland Street portrays nurses negatively in my opinion, it does do a lot of good through educating people on the importance of a healthy lifestyle. I feel sure that this benefits nurses in the long-term.

ER invokes in me the urge to work in an Accident and Emergency Department but I am slightly discouraged by the display of professional chauvinism shown by doctors, towards nurses. In this instance I would hope reality has yet again been submerged by rhetoric.

References

T.V. 2., (1944, 1995, 1996). Shortland Street.

T.V. 2., (1995 and 1996). ER.

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The Effects of Pregnancy on Self Esteem and Body Image

Introduction

The purpose of this article is to explore the effects of pregnancy on self-esteem and body image in women at different stages of the lifespan. Erikson's psychosocial theory of development provides the framework for the study (Turner & Helms, 1987). Interviews were conducted with two women who experienced pregnancy during adolescence and two who were in early adulthood when they became mothers. The names of these women have been changed to ensure their anonymity.

Defining self esteem

Self esteem is the value we place on ourselves, "a measure of how much we like ourself the way we are" (Johnson, 1991, p. 211). We are not born with self esteem, we acquire it from two primary sources:

1. Others: A child gets a sense of his or her value from relationships with significant others, for example family/caregivers. If these people communicate to the child that they are special, loved and valued this lays the foundation for positive self esteem (Sundeen, Stuart, Rankin & Cohen, 1989).
2. Self: We develop self esteem by analysing how well we match up to our own standards. Everyone has a self concept - an individual's feelings and beliefs about themself, and a self ideal - the kind of person they would like to be, how they think they should behave, what they would like to achieve. When an individual's self concept and self ideal are vastly different they will experience low self esteem (Sundeen et al 1989). Self esteem, self concept and self ideal are dynamic therefore an individual's experience at school, work and with other people may enhance or detract from his or her self esteem.

Defining Body Image

Body image is defined by Sundeen et al (1989) as all the conscious and subconscious attitudes an individual has towards his or her own body. This is how a person feels about their body's size, function, appearance and potential.

Adolescence, Pregnancy and Body Image

Both of the women interviewed were very concerned during the pregnancy about what they would look like afterwards. Helen related, "The impression you get is that once you've had a baby you're ruined, never be the same." She was worried that people would look at her and think, "She's had a baby, she's fat and ugly." After the birth of their babies both women said that their weight was a problem for them - even though neither of them appeared to be overweight.

Not having a partner was a big factor for Helen. She wondered if she would ever be considered attractive or find a life partner. Now she does have a supportive partner and even though she has not lost all the weight from her last pregnancy it is not an issue because her husband loves her and constantly tells her that he thinks she is beautiful. She knows that she is loved regardless of her appearance.

The negative body image experienced by adolescent women during and after pregnancy has implications for the resolution of Erikson's psychosocial crises of early adulthood - intimacy versus isolation. Their feelings of being unattractive and undesirable may hamper their ability to develop and maintain intimate relationships with members of the opposite sex.

Early Adulthood, Pregnancy and Body Image

In contrast these women did not worry about what they would look like after the pregnancy. It wasn't until after their babies were born that they realised the heavy toll pregnancy and child birth exacts on the body. As Sarah shared, "I felt as though my body had aged overnight and was past its use by date!"

Patti said that because of her changed body image she had difficulty having sex for a couple of months after the birth of her child. She is an aerobics instructor and a dancer and her body was always slim, supple and toned. Now having gained extra weight around the stomach and sporting dreaded stretch marks she felt that her body was no longer sexy or attractive. The negative body image experienced following child birth can cause a temporary crises of intimacy versus isolation even for women in stable relationships. For Patti this was a time when she needed intimacy to feel desirable and attractive yet she had difficulty receiving or giving intimately in her relationship.

Adolescence, Pregnancy and Self Esteem

For adolescent mothers the stigma associated with being teenaged, unmarried and pregnant contributed to

the low self esteem each already had. Both of the women interviewed had not resolved Erikson's psychosocial crises of adolescence - that of identity versus role confusion.

Helen had always dreamed of a career in medicine but these dreams were dashed by lack of parental support and poor decisions. She felt as though her life had no purpose and she had no support from her family. Her experience was that, "The further down people think you are the more of the real them you see and they don't mind telling you what they think." Some well meaning people at work tried to "take control" and without consulting her made an appointment for her with a counsellor and insisted that she go. Upon learning that she was planning to keep her baby another responded, "I hope that you aren't going to be one of these mothers who is too young to care for her child properly." She felt the weight of the decisions she had to make alone and live with for the rest of her life.

The negative attitudes and responses Helen encountered from people caused her to isolate herself even more and she felt "very low". Her self ideal had been to be a career woman and now she was faced with the prospect of being a teenage mum with only a high school education. This disparity between her dreams and her reality, coupled with the negativity and lack of support, made for very low self-esteem. In her own words, "It's a miracle that I'm still here, that I've survived."

In this case, having embraced the role of mother and committed herself to it, Helen was able to resolve the identity versus role confusion crises and has gone on to find intimacy in early adulthood in a very special relationship and with her own family. She is also pursuing a bachelors degree. Fiona on the other hand, still has not resolved the crisis of identity versus role confusion and although she opted to keep her baby is not committed to being a mother and relies heavily on her own mother to care for her child. She has not matured psychologically even though she is now in her early twenties, and places a low value on herself. This is indicated by the unhealthy relationships she allows herself to remain in.

Early Adulthood, Pregnancy and Self Esteem

The effect of pregnancy on the self esteem of young adults who are in stable supportive relationships seems to be related to their expectations of motherhood and the woman's childbirth and postnatal experiences.

Patti had a very straightforward birth and no problems with breast feeding or with her own or her baby's health. She felt wonderful to be able to provide all the nourishment that her baby needed and to have produced a happy healthy baby. She had a lot of support from her family as well as her husband and a very positive mothering experience. Her self esteem was enhanced.

In contrast, Sarah had complications with the delivery of her baby requiring a forceps delivery which was very painful and traumatic. She experienced breast feeding difficulties and almost immediately developed blistered nipples which became cracked and sore. In those first few days while she was recuperating and trying to adjust to breast feeding and routine she found the number of visitors and the constant presence of people overwhelming. At this time Sarah was very emotional and found that she cried a lot. The nursing staff offered her little support and one nurse said, "If you are like this now what on earth will you be like when you go home!" Consequently, by the time she went home she already felt as though she was not coping as she should be.

Continued attempts at breastfeeding were a nightmare and she finally opted to bottle feed. This decision brought more negative responses from friends and the visiting midwife who all believed that breast feeding was "the best way". Sarah felt very guilty about changing to bottle feeding and ashamed to have failed at being a good mother. She had an ideal image of how a "good" mother should be and act and feeling that she had fallen short of this standard, she experienced a period of very low self esteem.

Sarah later discovered an article which discussed the fact that for many women, "Breast feeding is grossly overrated" (Bond, 1995, p. 15). Women persevere with it because it is promoted as the best method and because "Some health professionals just aren't prepared to suggest bottle feeding" (Bond, 1995, p. 18). When women do choose to bottle feed they do so against the tide of popular opinion and often fail to receive the emotional support they need to help them overcome the grief of being unable to breastfeed.

About four months after the birth of her daughter, Sarah began to feel okay again. She said that she felt as though she was back to her normal self and no longer felt guilty. She also shared that she felt that if she had had an independent midwife she may have avoided or more easily overcome many of the problems she encountered.

Summary

The experiences of the women interviewed in this study suggest that for the adolescent who becomes pregnant, changes in self esteem are related to negative societal attitudes and the incidental responses they receive from people during pregnancy.

For women in early adulthood who are in stable relationships, self esteem is affected by their concept of good mothering and whether or not they live up to their own standards. In addition, the opinions of others they are in contact with (health professionals, family and friends) can contribute to high or low self esteem.

Negative body image is a big issue for the adolescent mother who fears that she is no longer desirable and may never be considered attractive enough to secure a life partner. This is an important issue for women as they move into early adulthood and may influence their ability to resolve the crises of intimacy versus

isolation.

For the woman in early adulthood, the altered appearance of her body and its new function (breastfeeding) requires a period of adjustment and may result in a feeling of physical isolation from a partner because the woman no longer feels sexy or attractive. In addition she may feel that she has lost forever the vigour and attractiveness of youth. This would seem to be a short term problem as the two women interviewed did adjust their body image and regained their confidence and appreciation of their bodies within a few months of giving birth.

References

Bond, B., (1995). From Breast to Bottle. Little Treasures, (48).

Johnson, K., (1991). Trusting Ourselves. Canada: Atlantic Monthly Press.

Sundeen, S. J., Stuart, G. W., Rankin, E. D., Cohen, S. A. (1989). Nurse Client Interaction (4th ed.). London: C V Mosby Co.

Turner, J. S., & Helms, D. B. (1987). Lifespan Development (3rd ed.). United States: Holt, Rinehart & Winston, Inc.

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Dreaming the Impossible: My Ideal Nursing Practice

Stephen Brunton, Clinical Practitioner and Tutor

Recently a colleague asked me what my ideal practice situation would be if I could have my choice. The prospect of being able to select my ideal nursing situation, unshackled by current realities, filled me with both trepidation and inquisitiveness. I had to ask myself what it is that I most want in terms of utilising my nursing knowledge and skills and what I most want for my clients. Having spent much time considering the issues I have concluded that my ideal nursing situation would be to work as an independent nurse practitioner in a community based primary health care setting. Several models have inspired me. I would like to explain what I mean by this definition of practice and what sociopolitical context would foster its development. I would also like to speculate whether my dream could become reality in Christchurch New Zealand.

Firstly I would like to clarify my ideal situation. I have taken my vision from that of several forward thinking nurses who over the last decade have created independent nursing practices in several places throughout New Zealand. In 1987 four Auckland nurses established a private practice with very clear aims. They wished to provide a relevant acceptable nursing service which was complementary to medical care (Allen, 1987). A previous pilot scheme initiated by Julie Martin and Ngaire Miller, also in Auckland, commenced earlier that year initially subsidised by the Government. They offered a general practice service based on wellness (Keene, 1988), returning to clients the responsibility for their own health and involving them in the decision making process about therapy. Many other nurses have set up similar services, some for a short term. Others such as Jennie Moore (1990) have integrated their practice into a community group providing other services as well.

In Nelson a further two nurses, Annette Milligan and Flavia Goulding began an independent nursing practice and have since gone on to win business awards and the respect of nurses around the country. In Christchurch, the Opawa Independent Nursing Practice is a personally observed inspiration. This service, based on a wellness model, continues to offer a range of services to its clients from adolescent health through women's health and on to older person's health. Its clients come from throughout the community and its services are contracted to several rest homes. Most of these practices offer a selection of complementary therapies in order to assist and empower their clients to achieve wellness.

A common thread running through all of these examples of independent nursing practice is that they are guided by a philosophy and theoretical perspective that is always recognised as nursing. Barrett (1993) suggests that nursing science based practices have the potential to become "the hub of the wheel of a new health care delivery system" (p. 116).

What will my independent nursing practice be like? I envisage a collective group of nurses, each with their own specialties, providing holistic client care and health assessment utilising a strong theoretical framework and offering healing modalities such as relaxation, therapeutic touch, imagery and meditation to enhance client wellbeing and power and to encourage clients to participate in positive change. On a more pedestrian level and bearing in mind the idealism of the situation, a full government subsidy would be available for each client necessitating only a small user charge. The practice would move out into the community as well, providing primary health care and education to interested groups and individuals.

In the establishment of any new venture there will always be frustrations and ambiguities. Those who have gone before have discovered many of these. Sonya Rosen (1988) writing six months after beginning her experience as an independent nurse practitioner emphasised the risk implicit in the venture. She stated that she and her group had to rethink what nurses could and should, and could not and should not do and not to limit themselves by holding onto their pasts. She suggested that letting go of the regular pay packet may be one of the more fearful aspects of becoming self employed in this setting. Miller and Martin (in Keene, 1988) also stressed the loss of secure income and working conditions such as sick and annual leave as an important issue. They also stated that many clients initially came to them for second opinions and because of dissatisfaction with other health professionals rather than because of what they specifically had to offer. I feel this last point may become a frustration in the short term because of the ambiguous public perception of nurses and nursing. It should be possible to overcome this through means of word-of-mouth recommendation and referral and effective advertising. The theoretical basis of my health centre may also be misunderstood, again due to a misperception of nursing. This has the potential to persist as a frustration but, it must be asked, is it necessary for clients to understand the theory behind the therapy as long as the therapy is successful?

Another frustration, potentially long term depending upon upcoming legislative change, is the inability of nurses to prescribe a limited range of medications. This may necessitate clients being referred on, creating a further cost for them. Hopefully this issue will be resolved within the next few years.

The ambiguity in the public's perception of nursing would also need to be overcome. Through more nurses

practicing independently, demonstrating effective skills and becoming more visible as legitimate health care providers I feel this ambiguous perception will slowly be overcome. This will be the case if the government moves to legitimise this service though subsidisation or contracting and freeing up prescribing practices.

Finally, the income limitations provide obvious frustrations as well as the expenses incurred in the initial setting up phase. Rosen (1988) has a possible remedy here suggesting that initially part time work in the independent practice combined with agency work may provide a satisfactory income while the practice is beginning to attract a regular clientele.

How will my practice relate to other health care providers? I see these relationships as collegial, complementary and respectful of each other's contribution together providing a comprehensive health service to consumers. I would like to see referral rights established between my health centre and these other health care workers. As Keene (1988 p. 27) states, "Independent nurse practitioners emphasise that their service is not a cheap alternative to that provided by doctors; it is different, meeting different needs."

How will my practice relate to its clients? I see this relationship as one of partnership and participation embodying the principles of the Ottawa Charter for health promotion, advocating, enabling and mediating. Helping clients into the best possible condition to heal themselves is my aim.

Goulding and Milligan (1993) state that from the outset they had to have a commitment to run their independent nursing practice in a professional and viable manner. It was suggested to them that they owed it to their clients to ensure that their practice continued to operate so that their clients would not be left without care. They also acknowledged the need as professionals to continuously update their knowledge base. Both of these statements are the goals of my practice. It is essential that one's knowledge base is regularly and effectively updated. Several polytechnics are now offering courses specifically for independent nurse practitioners. Waiariki Polytechnic offers a certificate in independent practice which involves all aspects of practice business management through to quality assurance (NZNO, 1993). It will be essential for me and my colleagues within the practice to regularly update our skills and become expert within our chosen specialties. A practice-wide system of quality assurance will be necessary too, involving client feedback among other measures. I also envisage a system of professional supervision to assist us in developing and maintaining our skills and to remain focused on our stated goals and our clients.

If I am to effectively facilitate the empowerment of my clients there are some things, socio-politically speaking, that need to change. Primary health care is in itself a philosophy with specific elements that must be taken into account if one wishes to practice from within this perspective. The philosophical elements of primary health care can be broken down into four main areas of social concern. They are

- social justice and equity
- international solidarity
- self reliance
- acceptance of a broad concept of health (Woods, 1992).

Takarangi (1988) states that nurses need to have a commitment to primary health care as a philosophy and to realise that it shapes all we are as members of our community and of our profession. A society based on the principles of primary health care, Habermas (in Clare, 1991) contends, is one in which there is an emancipatory interest which secures freedom from the domination and subordination inherent in all social relationships.

Habermas refers to this as undistorted communication. If a group or community is to make a rational decision about the provision of health care it is imperative that each member's views are heard and a genuine consensus is reached. These concepts have all but disappeared from the health system in New Zealand under the current health reforms. Even the outward appearance of democracy, voting for an elected health board, has been replaced by politically appointed boards and management. As recently as this year community consultation and submissions have been ignored by the Southern Regional Health Authority and Healthlink South with the proposed closure of the Templeton centre. It can be said that primary health care is also open to political manipulation but ultimately the philosophy encompasses all levels of society and is truly a universal health philosophy in every sense. For my clients to achieve personal empowerment, a society based on the principles of primary health care is needed. Indeed this is the case for the clients of all health care providers.

Am I dreaming the impossible dream? I think that my ideal nursing practice is possible but today's reality needs to change. Firstly, the current health care delivery system is not entirely conducive to independent nursing practice. While it is potentially possible for nursing practices to contract to the Regional Health Authorities to provide care to specific populations, this is difficult to achieve due to the authorities' misconceptions of nursing and because the independent nurse practitioner can not at this time provide comprehensive care. In 1991 the then Minister of Health, Simon Upton, justified the withdrawal of the independent nurse practitioner subsidy saying "The evaluation of the work... has suggested that subsidising the practices was a costly way of providing a service for a narrow clientele who could in many cases afford to pay for such services" (NZNA, 1991, p. 30).

Glick (1989) suggests that in order for most nurses to achieve in independent practice, changes must be

made in government policies and legislation including recognition as providers by the Accident Compensation Corporation, the liberalisation of prescribing rights and the provision of a partial state subsidy to independent nurse practitioners. In addition, she suggests that the independent nurse practitioner should be viewed as a colleague of the physician, complementary to each other, and to further facilitate this an education campaign should be run to inform general practitioners, legislators and the public about the contribution nurses can make to the health of the people of New Zealand. With the advent of MMP at this general election we may be looking at a more democratic system of government which is required to listen to the people and perhaps achieve undistorted communication.

For the optimist, the signs of change are promising and the possibility of my ideal practice becoming an easily achievable reality is only as far away as a new system of government. But for the pessimist, acknowledging that a great deal has to change in society and that that often takes a great deal of time is ultimately depressing. Although New Zealand was a signatory at Alma Ata and to the Ottawa Charter it does indeed take time to achieve legislative change. I will continue to hope and persist in the meantime along with my colleagues.

My ideal nursing situation, independent nursing practice, does exist here in New Zealand and continues to exist despite public and governmental misconceptions and lack of funding. Independent nursing practice can survive in a less than perfect environment but for it to flourish a socio-political change is necessary. And remember, nurses can change society.

References

Allen, N. (1987). What is independent nursing practice? New Zealand Nursing Journal, 81 (8), 2.

Barrett, E. (1993). Nursing centres without nursing frameworks: What's wrong with this picture. Nursing Science Quarterly, 6 (3), 115-117.

Clare, J. (1991). Transforming health care: Does nursing theory have anything to offer? Nursing Praxis in New Zealand, 6 (2), 5-9.

Glick, C. (1989). The occupational health nurse in independent practice. Nursing Praxis in New Zealand, 5 (1), 27-31.

Goulding, F. & Milligan, A. (1993). To know you must pay. Nursing New Zealand, 1 (4), 26.

Keene, L. (1988). Pioneers in independent practice. New Zealand Nursing Journal, 81 (4), 27-28.

Moore, J. (1990). Community health for the 1990's. Nursing Praxis in New Zealand, 6 (1), 22-26.

New Zealand Nurses Association. (1991). Nurse practitioners lobby minister. New Zealand Nursing Journal ,84 (3), 30.

New Zealand Nurses Organisation. (1993). Certificate in independent practice starts. Nursing New Zealand, 1 (2), 8.

Rosen, S. (1988). Working as an independent nurse practitioner. Nursing Praxis in New Zealand, 3 (3), 29-30.

Takarangi, J. (1990). Health cities. An international movement: Are we ready to participate? Nursing Praxis in New Zealand, 5 (2), 7-10.

Woods, M. (1992). Philosophical issues in primary health care in New Zealand. Nursing Praxis in New Zealand, 7 (1), 22-27.

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Beginning Journeys - Volume 2

Nursing Informatics !!??

Why Don't You Say it Just Means Computers?

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(This paper was first published in Nursing Informatics New Zealand, Inc. (1996). Informatics: Shaping the future. Proceedings of the Nursing Informatics New Zealand, Inc. Conference, Informatics: Shaping the future. Auckland: Nursing Informatics New Zealand, Inc.)

The title of this paper is a question commonly directed to staff by people enquiring about nursing programmes at Christchurch Polytechnic. The writer has some comments about this; while giving an overview of Nursing Informatics in the programmes of the School of Nursing, Midwifery and Health Education.

Introduction

From a philosophical or sociological perspective, there is a certain irony about Nursing Informatics, with its binary underpinnings, recently becoming an integral part of a new nursing degree curriculum that follows a critical social science pathway and which emphasizes process rather than outcome. Although the destination is still rather uncertain, nursing is moving from the behaviourist paradigm signified by the 'scientific' model and the nursing process. Some nurses were able to become very comfortable with the nursing process; others did not wish to do so; and still others have changed their minds about it (Bevis, 1993). Although many nurses were very successful in resisting the nursing process and its limitations, it is doubtful that this is possible with information technology.

It is important, however, to remember that information technology is only a tool to be used to achieve goals, just as the nursing process was intended to be. Sufficient knowledge to use this tool well is required, although not an 'in depth' understanding of its construction. Fortunately, while the software programmes are technically more complex, they are becoming increasingly 'user friendly' for learning purposes. Part of the necessary learning about information technology, also relates to what it does not do, as well as the things that are now possible. When part of one's daily activities consists of using well designed programmes; obtaining information from different countries in minutes; sending messages or receiving them from all around the world; and connecting to international nursing resources in seconds, it can be quite difficult to remember the machine does not think; that a click of the switch makes it all stop. A realistic understanding of the binary nature of the media assists sometimes, when confronted by one's own knowledge limitations in making the machine or a programme work.

Learning Resources

The School of Nursing, Midwifery and Health Education has its own networked file server (for those more technically minded, 486 DX4, 32MB RAM and 3 GB HDD) and a 16 terminal suite, managed by the writer, which gives some advantages and disadvantages for the approximately 500 nursing students involved. Disadvantages include that floppy disk access is not available for students, partly because of the amount of support required by the students in using the facility; the risk to the network of viral or other infestations; the risks of hacking or cracking; and the downloading of software from the network. Advantages for the students include role modelling of 'trouble shooting' during classes, which has had the effect of increasing students' awareness of their own capabilities; no classes being cancelled due to lack of technician support, especially in the evenings; individualized logins and passwords which simulate the reality of organizations that have management information systems and patient databases; a planned and organized setup of software to meet group needs and flexibility in changing the setup to meet the needs of any individual student at a particular time. Also, unsupervised access is restricted to nursing students, so it is possible to practise in relative privacy. Every academic staff office has a Windows capable machine and all staff use e-mail, with many now having word processing skills.

Nursing Informatics in the Degree Programme

The Bachelor of Nursing (BN) at Christchurch Polytechnic has six stages, two in each of three years. Stage Three, in the first semester of the second year has an Introduction to Nursing Informatics paper and the three remaining stages in the degree each have one paper involving Nursing Informatics. To date, Stages Three and Four have been completed, Stage Five is being undertaken at present for the first time and Stage Six is to be introduced in the second semester of 1996.

Table 1: Structure of Nursing Informatics Papers in BN

Year	Stage	Hours	Paper

Two	3	26/36	Introduction to Nursing Informatics
	4	14	[Research and] Nursing Informatics: 1
Three	5	10	[Research and] Nursing Informatics: 2
	6	15	[Research and] Nursing Informatics: 3

The four papers are included in the Midwifery degree to begin in 1997. Introduction to Nursing Informatics is compulsory in the Transition Degree, for registered nurses wishing to further their education. This degree takes the equivalent of a full time year. An optional paper is also available for these students, and has the same content as in Stages Four and Six of the BN. The Stage 3 paper, as Introduction to Informatics in Health Care is also conducted for students undertaking Pre Health Science courses; if completed before entry to the BN, the paper is directly cross creditable.

Stage Three: Introduction to Nursing Informatics

Two groups have completed this paper to date. The need for it still exists, because students generally do not have sufficient skills on entry to the programme. Although the student population is changing, age does not appear to be a related factor. The course begins outside the computer suite, with discussion about the technology and its possible effects upon people unused to it. In every class, students' abilities and experiences are so varied, that there is usually a range from very uncomfortable to positive or very comfortable. Some students have found it difficult to believe the stress reactions that others could demonstrate in the computing environment, and sharing of this and similar experiences has enhanced cooperative and collaborative learning in the whole paper. Students can negotiate about assessment times if they consider they are not ready to be assessed in any area. The longest extension so far has been eight months; everyone has succeeded. They may also negotiate about the type and extent of the assessments; some students have wished to present more than was given as a guideline and others have requested their starting point and the progress they have achieved, to be considered.

The content of the paper includes learning about hardware; systems and applications software; privacy, confidentiality, legal and security issues; networks and connectivity; ergonomics and environmental issues. The paper begins with theoretical concepts and no 'hands on' expectation. Initially, students have access via the terminals in the nursing suite, to the Open Public Access Catalogue and various CD-ROM databases (including the Cumulative Index to Nursing and Allied Health Literature (CINAHL) and the Educational Resources Information Centre (ERIC)) in the library. Still character based, access has been specifically designed to be very easy to use. As the paper progresses, students are gradually introduced to different types of software, including presentation graphics and a bulletin board (BBS). This will shortly be replaced by the World Wide Web (WWW) on the Internet, as the polytechnic is currently setting up a Web server. On completion of the paper, students have some ideas about presentation of word processed information and have continued access to the network to practise their skills.

Although the Introductory Nursing Informatics paper is not necessarily about nursing per se, it is facilitated by nurses, in a nursing and health context and in a manner that is conducive to nursing ways of knowing. Some rewards of the past year are exemplified by the students who, after the first four or five lessons say, "Now I talk about this with my [father, mother, sister, brother, husband, boyfriend, flatmate] and I know what they mean." Or the student who requested an undergraduate 'assistant lecturer' position so that she could assist in teaching this year.

A hardware upgrade in mid 1995 meant that it was possible to change from a character user interface to the graphical environment of Windows™ (under Novell Netware). The Microsoft Office Professional™ programme is used by students. This has meant changes which appear to be more positive, at least in terms of initial screen presentation; however, it does not help the teacher when a student double clicks (instead of single clicking) on a file which they wish to copy from a shared directory to their own area. Initially, limited knowledge about printer queues has caused students to realize the cartoons they see about screeds of paper pouring out from the printer are actually possible.

Later Stages

The paper in Stage Four introduces students to basic concepts of spreadsheets and database management systems with emphasis on uses for nursing and expects that they will have maintained or increased skills in word processing. This is usually the case, as major group assignments have been completed for other classes. The variety of innovative uses of the programmes continues to increase. The paper has currently been completed by one group of 60 students. Although the exercises were about nursing matters (a spreadsheet for calculating salary payments; a spreadsheet related to ward management; setting up a small database; and using a patient database) students said they found it difficult to see relevance to their clinical practice at the time. They were mainly in the community health or obstetric areas. Even the existence of considerable laboratory technology in general medical practice did not seem to be visible to the students.

A different reaction was obtained from nurses, with no spreadsheet experience, in the part time Transition Degree. Several requested to complete the exercise because they had no idea how to produce a spreadsheet. It was very noticeable that people who had management experience were particularly

enthusiastic as they realized what they could do.

There have been interesting changes in nursing computer suite usage and student behaviour during the last year. Pressure upon resources is usually very obvious in computing suites in other areas of the polytechnic, such as the Faculty of Commerce. It is common practice for enrolled students to be allowed to use spare terminals in any class when the tutor agrees. This had not been commonly requested by nursing students. In the latter part of 1995, every terminal was used most of the time. At times, it became difficult to sort out who was actually in class and who had come in their own time. There was also increased interaction between students in both Stages Three and Four as they assisted each other with problems.

Stage Five includes analytical graphic and research applications relevant to nursing and research. This stage is being undertaken for the first time and information is not available at the time of writing.

Stage Six takes a broader nursing and health focus, looking at issues of nursing in a technological age. As the programme was approved in 1994, there have been changes and more are planned to keep pace with the rapidly changing technology and with new information being published (Ball, Simborg, Albright, & Douglas, 1995; Grobe & Pluyter-Wenting, 1994; Mills, Romano, & Heller, 1996) about the growing science of Nursing Informatics.

Shaping the Future

Nursing Informatics was a single course in the Diploma of Nursing programme at Christchurch Polytechnic from 1990, until the end of the programme in 1993. The enthusiasm that is now present, did not exist then, except in a few individuals. There are probably several reasons for this, not the least being that it is no longer a single course, to be endured, then forgotten.

While many nurses and students of nursing still find initial difficulty, especially with the language of information technology and computers, this is changing as more become familiar with information technology; its benefits and its limitations. It is also time to begin graduate programmes for this generation of nurses. Nursing must value and support these people as they master the language (Foucault, 1969/1972) (and the skills) that will generate future Nursing Informatics knowledge. That is why we do not say, "It's just computers."

References

Ball, M. J., Simborg, D. W., Albright, J. W., & Douglas, J. V. (Eds.). (1995). Healthcare information management systems: A practical guide (2nd ed.). New York: Springer-Verlag.

Bevis, O. M. (1993). All in all, it was a pretty good funeral. Journal of Nursing Education. 32(3), 101-105.

Foucault, M. (1972). The archaeology of knowledge (A. M. Sheridan Smith, Trans.). London: Tavistock Publications. (Original work published 1969).

Grobe, S. J., & Pluyter-Wenting, E. S. P. (Eds.). (1994). Nursing informatics: An international overview for nursing in a technological era. Proceedings of the fifth IMIA international conference on nursing use of computers and information science. Amsterdam: Elsevier.

Mills, M. E. C., Romano, C. A., & Heller, B. R. (1996). Information Management in Nursing and Health Care. Pennsylvania: Springhouse Corporation.

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CHRISTCHURCH POLYTECHNIC INSTITUTE OF TECHNOLOGY Te Wānanga o Ōtautahi New Zealand

Nursing, Nursing Education and Economic Rationality

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The purpose of this paper is to illustrate how the contradictions inherent in operating within both an ethic of responsible care and economic rationality pervade inter-subjective understandings of nursing practice and nursing education.

Nurses occupy a number of contradictory positions - in relation to the means of production and the institution of the health system, their education, their relationship to the medical profession and to the patients but represent a symbolic ordering or society that many would not question, or not see as related to nursing activities. The symbolic and material positions interrelate in such a way as to make analysis of just what nursing is or is trying to accomplish, problematic. Many nurses and those involved in educating nurses feel pessimistic about the power of nurses to define what nursing is, or should be, within an economic and political climate which reduces most nursing activities, as well as nursing education, to the ethos of the 'market place'.

'Market-speak' is an appropriation of language by New Right ideologues who have the power (and visibility) which brings to our everyday understanding new definitions of our relationships with others who provide, and those who use health care services. Health care provision, like any other 'consumer' service, requires a 'value for money', kind of accountability, most often 'measured' by 'efficiency' and 'effectiveness'. However, these terms mean different things to different people depending where in the system they stand. Crown Health Enterprise, (C.H.E.) managers accountable to Regional Health Authorities (R.H.A.s), doctors and nurses accountable to 'clients'and professional standards, patients with (constructed) subjective, understandings of their health needs, nursing educators accountable to students and educational hierarchies, all will have different conceptions of what is 'value for money' in relation to nursing practice.

This discourse defines health needs as a commodity, something attainable in terms of 'value for money', and indicates how far we have incorporated 'market-speak' into the fabric of everyday conversation. I would suggest that the incorporation of 'market-speak' in relation to health care can act against nurses 'and nurse educators' interests at a time where there is a concerted drive to raise the visibility and value accorded nursing as a profession.

The way in which an economic rationality has invaded our perceptions of the reasoning behind so many of our actions and behaviours has consequences which need to be explored, made visible, and challenged.

How can nurses and nurse educators maintain a profession based on an ethos of caring responsibility in a society where human interaction is increasingly defined by economic responsibility? Is accountability an equation of 'value for money' or a moral and ethical responsibility? We have been led to believe they can be. If this is so why then is there such unrest and discomfort amongst those in the health professions, resignations of C.H.E. managers, patient protests about the state of the health system, questions about inequities of de-institutionalisation?

Doctors, despite ongoing restructuring of the health system, have retained the right to charge patients directly for their services. The economic relationship between doctors (in the primary and private sectors) and patients is quite clear. I suggest that the perception of a direct economic relationship is carried over into the secondary sector, that patients do not differentiate between those doctors working in the secondary and primary or private sectors in terms of their perceived economic relationship. An outcome of this relationship is public support for the medical profession on issues which are politically pursued, for example, the case for cardiac surgery in Christchurch.

Nurses, by contrast, whether working in the private or public sector (with the exclusion of those in private practice who charge patients directly) do not have the means to enter directly into an economic relationship with their patients. Their relationship, by contrast, is presumably formulated around an ethic of care, divorced from direct payment of services provided. If we acknowledge that humans, as a result of prolonged exposure to 'market-speak' are actors concerned with maximising self-interest in economic terms how might patients see their relationship with nurses in these terms? Is it possible the relationship might pivot around perceptions of 'value for money' even though money is not directly exchanged? I am suggesting it is possible that nurses' activities and interactions are defined reflecting patients' perceptions of nurses as actors economically responsible to patients even though nurses may argue that is not the basis of their relationship.

Describing the basis of relationships between different groups, for example between nurses and patients, often involves concepts such as 'responsibility', 'care', even 'love'. While these concepts may be seen as emotional and value laden - and they are - they have been visible, present in our lives and we are able to describe behaviours and activities which represent those symbolic concepts. These bases for human interaction have, over the past decade, been subsumed to relationships of economic rationality. For

example, family 'responsibility' has become the imperative of families to pay for their children's education, to provide a home to decrease flatting costs, hence 'responsibility' reflects an ethos and inter-familial relationship based upon economic rationality rather than an ethos of 'caring responsibility': likewise the relationship between nurses and their patients.

When nurses argue for their caring work to be valued, their professional expertise to be accorded (increasing) educational status, they appear to be largely unsuccessful, even by their own self-perceptions. I would suggest this is partly because they are unaware of how their relationship with patients, with the medical profession, is influenced by the ethos of economic knowledge, whether or not this is articulated. That doctors and nurses care for a patient or patients in common exacerbates the possible dimensions of split 'loyalties' whether or not patients articulate these responses.

The question arises, is it possible to educate nurses and to practice nursing from an ethos or caring responsibility within a pervasive economic rationality? Do we ignore this economic and political context in the hope that so-called 'emancipatory knowledge' and the moral responsibility to care for others will prevail, at least in nurses' consciousness; and ideally to be translated into the delivery of nursing care itself? The ultimate question is - how can nurses deliver nursing care from a philosophical background of responsible care in a climate which reduces many (intimate) interactions to that of the market-place? Will extending and improving the 'quality' of nursing education necessarily provide the right context for responsible care to be practised as well as achieving professional recognition and appropriate pay scales?

Increasing intellectualisation of nursing practice on its own will not necessarily achieve any gains in the competition for increased jurisdiction over patients in relation to their health needs. Neither will it necessarily give nurses political leverage to define nursing as a necessary and crucial component of health care. One has to question the emergence of 'case nursing' at this particular time and critically examine its origins. Whose needs does this model best meet? Does the model challenge or suit an economic rationality which claims to be based around patient needs being met 'efficiently' and 'effectively'?

I would suggest that our educational programme, the drive towards increased credentialism without a strong politically active, collective voice reinforces the ethos of economic rationality. Action is implicit in the concept of emancipatory knowledge but what is that action to be in the context of further restructuring and the ever increasing powerlessness of nurses to define a working reality based on a moral ethic of responsible caring as well as providing 'value for money'?

References

Bunkle, P., Lynch, J. (1992). What's Wrong with the New Right in Celia Briar, Robyn Munford, Mary Nash (Eds.). Superwoman Where Are You?. Palmerston North: Dunmore Press.

Pusey, M. (1991). Economic Rationalism in Canberra. Sydney: Cambridge University Press.

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Beginning Journeys - Volume 2

Cooperative Learning: Beneficial for Nursing Education?

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Jackie Walker is a nursing tutor teaching in the areas of nursing research and long term health problems. She has a special interest in the processes of teaching and learning and facilitating effective learning.

Introduction

One of the aims of tertiary education is to develop the student's application of knowledge and to challenge their conceptions about the world. However, traditional teaching methods have been criticised for not achieving these outcomes. Teachers now recognise the value of problem based learning and small group projects as they encourage both critical analysis and reflection on the processes of learning. Cooperative learning (CL) is being increasingly used in the tertiary setting to help address these concerns.This move towards student centred learning is partly in response to criticism from employers that students are not able to work cooperatively and independently when they graduate (Ramsden, 1992). Critical analysis and problem solving skills are also essential for registered nurses to function in the rapidly changing health service. This paper will identify the benefits of CL in relation to nursing education, the ways it can be used effectively and the issues to be considered. Concepts of teaching and learning and how these link with CL will be briefly discussed.

Cooperative learning

Cooperative learning (CL) is characterised by students working together on a series of academic tasks and promoting each other's learning through explaining, discussing and sharing their knowledge. It is a cooperative, not competitive activity, where effective teamwork is emphasised. Students are held individually accountable both for their own learning and the learning of the group members.

Cooperative learning strategies have been used in a variety of programmes, from maths to social sciences, and recently in nursing programmes (Goodfellow, 1995). In nursing education, cooperative learning has advantages over other learning methods because nurses generally practice in small teams or collaborate closely with other health professionals (Beck, 1995).

What are the advantages of cooperative learning over other ways of learning?

A review of 122 studies which compared the relative effectiveness of cooperative, competitive and individualistic learning on individual learning and proficiency, at the tertiary level, found some distinct differences (Johnson, Johnson & Smith, 1981 as cited in Goodfellow, 1995).

Cooperative learning "promoted higher individual knowledge, proficiency and achievement, greater interpersonal attraction among students, greater social support, and higher self-esteem than competitive or individualistic efforts" (Goodfellow, 1995, p. 26).

Research has supported the benefits of cooperative learning on the grade achievement of nursing students (Fuerson, Isom & Webster, 1984 as cited in Beck, 1995; Goodfellow, 1995). Other studies have indicated higher grade point averages using cooperative learning compared to individual (traditional) learning (Tinto & Love, 1995; Hwong, Caswell, Johnson & Johnson,1993). However in two studies individual learning students did better than cooperative learning students (Griffin, 1994; Klein,1994).

Whilst the academic benefits of CL may be equivocal, studies have clearly demonstrated the positive benefits as perceived by students. In a study by Tinto and Love (1995), CL students had a more positive perception of the class, faculty and campus, they were more likely to express an interest in higher education and found the group work more fun compared to traditional students. Another benefit from CL may be the retention of students, particularly for mature students or those returning to higher education. This may be linked to the group support that students receive in a non-competitive environment (Adams, Carlson & Hamm, 1990). Higher rates of course satisfaction have also been found in studies involving CL (Rieck, 1995).

Other perceived benefits of CL include the movement of responsibility for learning from the teacher to the learner which helps to promote life long learning. Also the quality of work produced by the group is higher than that which is produced individually. CL also reinforces the concept of peer learning and validation of the learner's past knowledge and experience (Lejk, 1994).

For CL to work effectively five elements need to be structured carefully by the teacher (Goodfellow, 1995).

These include:

1 Positive Interdependence

This can be developed through mutual goals, joint rewards, divided resources and complementary roles

(Johnson & Johnson, 1987, as cited by Goodfellow, 1995).

2 Face - to - face interaction

This is the interaction and verbal discussion, promoted by the positive interdependence, that influences student involvement. Interaction can be enhanced by seating arrangements and encouraging the exchange of ideas and cooperative work on a specific task in class time.

3 Individual accountability

Working in groups may blur the boundaries of individual accountability. In CL groups, individual accountability exists when the performance of each member is assessed. This gives feedback to the group on who needs more help in completing the given task. Goodfellow (1995) used midterm and final examination results so groups could review their results. If several members missed a question, it was the responsibility of the other students to provide the rationale and help them understand the correct answer.

4 Collaborative skills

Students need to use these skills to ensure the group process works effectively. Collaborative skills include leadership, decision making, trusting, communication, and conflict management skills. The development of these skills requires both time, role modelling and regular evaluation of group process. Through role modelling the teacher can encourage the sharing of ideas, give feedback for good decisions made and intervene to help some students solve problems.

5 Group processing

It is beneficial if groups spend about 10 minutes per week assessing how well they are achieving their goals and which group members are contributing. Although there may be initial difficulty and resistance, each person takes a turn to evaluate each others work, provide encouragement and express any concerns. This feedback helps the groups to learn to work together productively.

These essential elements can be fostered or highjacked by both students and teachers. In facilitating CL, it is crucial that the teacher models these elements and performs ongoing evaluation of the learning climate created by each group. Strategies which can help groups to develop interdependence and cohesion, which then help members to deal with conflicts and assist task completion can be discussed and fostered by the teacher. A group size of 6-8 can work effectively, though the smaller the group the greater the group cohesion and individual accountability.

Gibb (1995) suggests several strategies to encourage discussion and task completion in the groups. Rounds, where each person speaks on a topic, are useful to initiate discussion. Buzz groups and Brainstorming sessions, where ideas are only analysed at the end, generate creativity and group involvement. The 'Pyramid' method is where a problem is worked on individually for 5 minutes, then worked on in pairs for 15 minutes, then tackled in groups of 4-6 for 30 minutes, with a plenary session of 10 minutes. This method encourages the development of group process whilst completing the set task. The 'Syndicate' method involves teams of students working parallel on the same task for a certain time and concluding with a short plenary session to share everyone's ideas and actions.

Any group work is disadvantaged when conflicts and poor individual accountability jeopardises group process and task achievement. Gibb (1995) discusses a variety of tactics which can deal with problem incidents in groups. These tactics are underpinned by the need for clear structure and guidelines related to group process and outcomes. Using a group contract to identify roles and individual responsibilities can be useful. Glendon and Ulrich (1992) developed a more structured model where students had required pre-reading and then worked on CL strategies in small groups to apply the knowledge learnt in the pre-reading. The three strategies, Think-Pair-Share, Roundtable and Pass the Problem, encouraged the students to problem solve, analyse, generate ideas and give feedback on the solutions to each other. Students soon realised the importance of the pre-reading as they had to actively participate in turn.

The role of the teacher in CL involves five facets: planner, clarifier, stimulator, coordinator, and evaluator (Beck, 1995). 'Planning' is important to keep the groups on task and to ensure that reading materials are distributed to facilitate class discussion later. The role of 'clarifier' involves clarifying tasks, discussion questions, issues from the reading materials and clarifying expectations. The teacher takes on a 'stimulator' role by asking thought-provoking questions in both small and large group discussions. In the 'coordinating' role, the teacher explains the group task, time frames, resources and dates for assessments. It is important to give some structure to the class but to also have the flexibility to change to meet student needs as they arise. The 'evaluator' role of evaluating individual and group learning is, ideally, shared with the students. It can involve using learning contracts, peer evaluation, self evaluation and teacher evaluation (Beck, 1995). Glendon & Ulrich (1992) discuss the difficulty teachers may have in adapting to the different roles required in CL, where they seem to give up their expert role and are no longer the centre of attention.

How do the student's perceive CL?

Initially, students often feel uncomfortable with CL and miss the structured lecture method of teaching (Glendon & Ulrich, 1992). However, several studies have highlighted positive perceptions (Wesp, 1992; De Young & Adams,1995). The sharing of ideas, being exposed to different perspectives and learning from each other are positive outcomes for students (Gross, 1994). Team work and communication skills are enhanced

in CL (Glendon & Ulrich , 1992). Beck (1995) argues that cooperative learning within a feminist pedagogy is particularly useful for nursing students. The majority of nursing students are women and they tend to work better when there is an atmosphere of relatedness and connectedness (Gilligan,1982 & 1990 as cited in Beck, 1995).

There appears to have been little research into different ethnic or cultural groups response to CL, however Jagers (1992) examined the attitudes of 120 Afro-American students towards interdependent and independent learning contexts. These students demonstrated a cooperative attitude in their learning and this positively impacted on their academic motivation. One could speculate that ethnic groups which have strong cooperative cultural norms, such as polynesian people, might learn more effectively in CL groups.

Assessment

The assessment of student learning in CL groups has generated much debate. Should the assessment tool be individually based, group based or a combination of both? Should individual contributions be recognised or is it only the group project which is assessed? How does the teacher fairly award a mark or grade to a group project? Lejk (1994) discusses using peer assessment by team members to help the teacher to award marks fairly. Team members also share out marks based on individual contributions. The assignment is divided into individual and team based work with 25% of the final assessment based on the teamwork assignment. To encourage both group task and group process, the assessment covered both the solutions to the task (70%) and team building, management and monitoring (30%) (Lejk, 1994). Gross (1994) used a cooperative learning situation (eg group interivew of family) to enable individual completion of an assignment (eg a nursing care plan), so overcoming many of the difficulties of marking a group project. As student learning is enhanced by regular feedback through assessment, teachers need to carefully consider when and how they schedule assessments for CL groups. Formative assessments early in the course and summative assessments, with a higher weighting, later in the course allow for the development of effective working groups (Ramsden,1992).

Cooperative learning and concepts of teaching and learning

If cooperative learning is viewed as an effective learning method how does it link with what is already known about good teaching and learning practice? What do teachers conceive teaching to be? What do learners perceive is learning?

Conceptions of teaching

Various classifications have been proposed to explain differing conceptions held by teachers and how they link to the teacher's and student's roles. One broad classification is 'teacher - initiated' learning and 'student initiated' learning (Fox, 1983 as cited in Samuelowicz & Bain, 1992). Another classification places the conceptions on a continuum from presenting information to facilitating student's learning (Martin & Balla, 1990). Samuelowicz and Bain (1992) qualitatively studied the conceptions of teaching held by academic teachers and identified five dimensions of teaching.

Level 1:

Teaching as supporting student learning.

This is a student centred activity where students are in control of the content of their learning and also take responsibility for the process of learning. This conception was only held by teachers at post-graduate level where teaching is on an individual basis and focussed on the learner's needs to achieve a 'deeper learning'.

Level 2:

Teaching as an activity aimed at changing students' conceptions or understanding of the world.

In this conception the outcome of the teaching and learning process is different knowledge as opposed to increased knowledge. Using factual knowledge, skills and theories from a discipline, the emphasis is on developing an appropriate conceptual framework and developing creative, independent thought. The aim is to change students' conceptions from naive ones to those held by experts in the discipline. The teacher's role is to start from the student's conceptions and help their development by challenging or building conceptual bridges to the 'higher' concepts. An example from nursing education would be the teaching of cultural safety concepts over a three year programme.

Level 3:

Teaching as facilitating understanding.

Here the emphasis is on enabling students to gain enough knowledge that they can understand it and apply the knowledge to new situations. The teacher's ability to explain, clarify and interpret the material is essential to the learning process. In learning the knowledge, skills and attitudes of the nursing profession, the ability to apply these to a variety of practice contexts and patients/clients is essential.

Level 4:

Teaching as transmission of knowledge and attitudes to knowledge within the framework of an academic discipline.

Teaching involves helping undergraduate students to acquire a defined body of knowledge, concepts and skills which will enable them to train for a future profession. In pre-registration nursing programmes, students learn concepts from the physical and social sciences which provide a foundation on which to build nursing knowledge and skills.

Level 5:

Teaching is imparting information.

Teaching is seen as a teacher centred activity where information is told to the students. The teacher needs to be knowledgeable in the subject, be well prepared and use her/his own enthusiasm and experience rather than the students'. There is one correct answer and it is the teacher's role to give the answer or help the students reach it. This occurs in nursing education when visiting 'experts' come and teach very specific information, based on their experience, which is not easily accessible.

In analysing the place of CL in these conceptions of teaching, it appears applicable to level 2, 3 and 4. Depending on the way the projects or tasks are structured, teachers will facilitate the transmission of knowledge (level 4), facilitate understanding (level 3), and change conceptions about the discipline (level 2). This attests to the flexibility and generalisability of CL across different levels of teaching.

Conceptions of learning

Learning is a complex process involving both the learner, the teacher and the context of learning. The learning process cannot be discussed without examining conceptions of learning held by learners.

A study by Marton, Dall'alba and Beaty (1993) identified six qualitatively different conceptions of learning. Learning was seen as:

a) increasing one's knowledge
b) memorising and reproducing
c) learning as applying
d) learning as understanding
e) learning as seeing something in a different way
f) learning as changing as a person

The first five conceptions were also identified in earlier research (Saljo, 1979 as cited in Marton et al, 1993) but the last conception is a relatively new one. For example, the teaching of feminist knowledge often brings about this type of 'change as a person' learning for women.

CL can produce learning in each of these areas, depending on the task, but would most often develop learning as applying and understanding and seeing something in a different way. CL may also produce learning that changes a person's behaviour long term. There is an element of cooperative learning in many drug dependent programmes where people work on tasks together (strategies to maintain sobriety), learn from each other (group counselling sessions) and have a 'teacher' to facilitate this learning process.

Jaques (1994) provides a useful discussion of how conceptions of learning and teaching interlink from the student's perspective. He identifies that students who perceive learning as 'reproducing' believe that the teacher should "do all the work and make all the decisions" (p. 48). Students who see learning as 'making sense' see the teacher's role as setting the learning climate, making resources available and supporting students whilst they take responsibility for learning. As CL fits very firmly into this last category, students holding the former belief will need support and more careful guidance through this learning process.

Limitations of CL

Cooperative learning has many links with what is known about good teaching and learning. What are some of the limitations of this approach?

The foundation of CL is having effective group processes and, as these need time to develop, cooperative learning is not well suited to very short courses. The group member's maturity can affect the development of group process skills and the teacher needs to continually facilitate the examination of group process by the group. This is not to say that age is a barrier to CL, as the method is used successfully in primary schools in the USA (Slavin, 1990). However, the teacher cannot assume effective group skills will just 'happen'.

The role of the teacher changes dramatically from the 'traditional' role and this involves developing skills in facilitation, conflict resolution and effective group process. For some people there is a perceived loss of the 'expert' role and the personal rewards that brings with it.

Another potential problem is the diffusion of responsibility, where an individual avoids the work and has a 'free ride' (Slavin,1990). It may be some time before an individual realises he/she cannot be passive and that the group will be penalised for this behaviour (Gross, 1994). This can be overcome by each person being responsible for a unique part of the groups task and individual accountability being rewarded through the form of assessment used. For example, the group's final mark is an aggregate of all the individual members marks (Slavin, 1990).

Conclusion

Cooperative learning is a teaching/learning method which develops many of the skills, attitudes and behaviours which are essential to function in today's ever changing society. Its effectiveness has been well supported by educational research and it has strong links with what is known about good teaching practice. Students develop many skills in problem solving, communication and collaboration. The teacher's traditional role as 'expert' changes and a broader range of roles are needed to facilitate learning. Whilst it has some limitations which need consideration, it is a method which is well suited to nursing education. The skills that CL develops are the very ones needed by registered nurses to practice effectively and creatively in the current, changing health service.

References

Adams, D., Carlson, H., & Hamm, M. (1990). Cooperative Learning and Educational Media. Englewood Cliffs, NJ: Educational Technology Publications.

Beck, S.E. (1995). Cooperative learning and feminist pedagogy - a model for classroom instruction in nursing education. Journal of Nursing Education, 34 (5), 222-227.

De Young, S. & Adams, E.F. (1995). Study groups among nursing students. Journal of Nursing Education, 34 (4), 190-191.

Gibb, G. (1995). Teaching more students: No 3 Discussion with more students. Oxford: Oxford Centre for Staff Development.

Glendon, K. & Ulrich, D. (1992). Using cooperative learning strategies. Nurse Educator, 17 (4), 37-40.

Goodfellow, L.M. (1995). Cooperative Learning Strategies: an effective method of teaching nursing research. Nurse Educator, 20 (4), 26-29.

Griffin, M.M. (1994). Learning through Testing: An investigation of Cooperative Assessment, Paper presented at the Annual meeting of the American Educational Research Association, New Orleans.

Gross, J.W. (1994). Learning Nursing Process: A group project. Nursing Outlook, 42 (6), 279-283.

Hwong, N.C., Caswell, A., Johnson, D.A. & Johnson, R.T. (1993). Effects of cooperative and individualistic learning on prospective Elementary Teachers' music achievement and attitudes. Journal of Social Psychology, 133 (1), 53-64.

Jagers, R.J. (1992). Attitudes toward Academic Interdependence and Learning Outcomes in Two Contexts. Journal of Negro Education, 61 (4), 531-538. Jaques, D. (1994). Learning in Groups (2nd ed.). London: Kogan Page.

Klein, J.D. (1994). Effect of of Individual versus Cooperative Learning and type of reward on performance and ongoing motivation. Contemporary Educational Psychology, 19 (1), 24-32. Lejk, M. (1994). Team Assessment, Win or Lose. The New Academic, 3 (3)

Martin, E. & Balla, M. (1990). Conceptions of teaching and implications for learning. Research and Development in Higher Education, 13, 1-7.

Marton, F. (1986). Phenomenography - a research approach to investigating different understandings of reality. Journal of Thought, 21 (3), 28-49. Marton, F., Dall'Alba, G. & Beaty, E. (1993). Conceptions of Learning. International Journal of Educational Research, 19 (3), 277-300. Ramsden, P. (1992). Learning to teach in Higher Education. London: Routledge. Rieck, W.A. (1995). An investigation into the Effectiveness of an Integrated Mathematics course for College Freshmen compared to traditional Algebra for College students. Published report, University of SouthWestern Louisiana.

Samuelowicz, K. & Bain, J.D. (1992). Conceptions of teaching held by academic teachers. Higher Education, 24, 93-111. Slavin, R.E. (1990). Cooperative Learning: Theory, Research and Practice. Boston: Alleyn & Bacon. Tinto, V. & Love, A.G. (1995). A Longitudinal Study of Learning Communities at La Guardia Community College. University Park, PA: National Centre on Postsecondary Teaching, Learning and Asessment.

Wesp, R. (1992). Conducting Introductory Psychology Activity Modules as a requirement for Advanced Undergraduate Classes. Teaching of Psychology, 19 (4), 219-220.

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Do Teaching Strategies have any Influence on the Way Students Learn?

Lynette Low RGON, BA, MEd, Nursing Tutor

The following evaluation was carried out as partial requirement for MEd, University of Canterbury in 1995.

In 1995, the School of Nursing, Midwifery and Health Education at Christchurch Polytechnic was in the final year of offering the Diploma of Nursing along with the Bachelor of Nursing. Tutors recognised that as nursing is a profession particularly affected by the impact of escalating technology and destabilisation, learning needed to be more than rule governed enquiry. Learning is being able to cope with unique or uncertain situations through reflection on past experiences. Therefore, to encourage reflective practice, teaching strategies in the degree programme differed from those used in the diploma, e.g. the tutors and students in the degree programme journal their experiences on a day to day basis with structures set in place to encourage reflection, enquiry learning was encouraged and Kolb's experimental learning cycle used as a framework for teaching.

While there may have been elements of the above strategies in the methods of teaching used with students in the diploma course there was a significant philosophical difference in the tutor perception of the student as an independent learner able to learn with direction (Diploma) to a student who is encouraged to find the direction (Degree).

One of the key evaluation questions therefore was, "Did this philosophical difference have any impact on the way students approached their learning?"

For the purpose of the study, "learning approach" was defined as the combination of intent and strategy a learner applies to a particular learning task. The use of the term was consistent with the literature (Speth & Brown, 1988; Biggs 1979; Van Rossum & Schenk, 1984). There were two main approaches to learning considered: a reproduction approach, where the student superficially studies a topic with the intention of fulfilling course requirements by memorising the material perceived to be important, and a meaning approach, where the student has the intent of understanding the meaning of the subject and is able to relate it to their previous knowledge and personal experiences.

Method

A published questionnaire, "The Lancaster Approaches to Studying and Course Perceptions Questionnaire" as constructed by Paul Ramsden (1983) was adapted to fit the local context and distributed to a random sample of 40 students in each programme.

Results

Students in both programmes were shown to predominantly use an approach to their learning that would assist them in making sense of the information and to think critically about the application of knowledge in a clinical setting. Students in the degree programme were utilising a reproduction approach to a greater extent than those in the diploma programme (ie a superficial study of the topic with the intention of fulfilling course requirements by memorising the material perceived to be important). This finding however may be dependent on the length of time in the course; with the degree students in the second year and the diploma students in the third.

An unexpected finding of the study was the ability of the students in the degree programme to manipulate their environment by moving outside the constraints of a highly structured questionnaire to give their opinion through the writing of comments and combining of responses on the Likert scale. The diploma students by comparison moved beyond the constraints very little. This is perhaps the most significant finding of the study. One could hypothesise that this resourcefulness is a product of the teaching strategies - an area for further research perhaps.

The study has several significant acknowledged limitations:
Future use of this questionnaire in this context should only occur after further work is carried out on the data to validate is appropriateness, and an effort is made to rectify or minimise the limitations. The study does provide a base line for further research however.

References

Biggs, J. B. (1979). Individual Differences in Study Processes and the Quality of Learning Outcomes. Higher Education, 8, 381-394.

Ramsden, P. (1983). The Lancaster Approaches to Studying and Course Perceptions Questionnaire. Oxford: Paul Ramsden and the Educational Methods Unit, Oxford Polytechnic.

Speth, C. & Brown, R. (1988). Study Approaches, Processes and Strategies: Are Three Perspectives Better

than One? British Journal of Educational Psychology, 58, 247-257.

Van Rossum, E. J. & Schenk, S. M. (1984). The Relationship Between Learning Conception, Study Strategy and Learning Outcome. British Journal of Educational Psychology, 54, 73-83.

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Beginning Journeys - Volume 2

Exemplar: The Helping Role

Keri Marlow, Bachelor of Nursing Student

Although my exemplar appears long, please bear with me; it explains my journey over a nine day period during Practicum I and includes extracts from five entries of my journal.

I will endeavour to portray my experience and the situations that occurred over this time span, relate them to Benner's 'Helping Role' and through reflections show how these experiences have contributed to my advancement in nursing practice.

Guiding a Patient through Emotional and Developmental Change Providing New Options, Closing Off Old Ones, Channelling, Teaching, Mediating

"Your second client will be a challenge!" These words spoken by my tutor still ring clear in my ears and I feel now that they were an understatement for the journey I was about to embark upon.

Mr C is an 80kg man, 82 years of age, diagnosed as having Dementia, NIDDM, left above knee amputation, impaired hearing, double incontinence and an aggressive nature - known to display regular violent outbursts both physically and verbally.

I remember my first encounter with Mr C vividly.

"The inevitable was about to happen I was procrastinating and had to psych myself into organising things for Mr C's wash. By this time I had three people to help me, it was after 1000. I presented myself as composed as I could and asked Mr C if he would like a wash. (I was trying to obtain consent from my client before proceeding as taught in theory.) I was promptly told to 'get the bloody hell out of it' as his arm flew out towards me. I was horrified, firstly at the rudeness of this man and secondly stunned at the thought - what do I do now? I obviously did not have consent. My tutor took control of the situation and told Mr C to behave himself. We proceeded with his wash with the occasional outburst that kept me on my guard. By the time we completed Mr C's wash, assisted toileting and had him seated in his day chair, I was at a loss as to my abilities of caring for him - I was frightened of Mr C and frightened of the nursing care I was to adopt for him. I was practising everything we are instilled not to do - namely 'doing to' a person. The manner in which we spoke to Mr C and got things accomplished did not sit well with me" (Journal Entry 7.6.95). I felt terrible and pondered on my thoughts.

After discussions with my tutor, I have concluded that my client is a 'no frills' man. Explanations of what we were doing annoyed him and gave him reason to lash out - maybe a reason but not a right.

"I found myself putting off the inevitable yet again and made myself take control of the situation. My attitude was to get Mr C ready for the day and no nonsense. With this in mind I readied myself to accomplish what I set out to do" (Journal Entry 12.6.95).

I adopted short simple statements/directives as to my intentions and expectations of him. I remember thinking at the time - I cannot show I am intimated by a man who refuses to admit to comfort.

"I am very aware of being dubious of Mr C's moods and how I am to deal with the situation; but also aware of feeling confrontations with this man" (Journal Entry 14.6.95).

After showing and dressing Mr C with several outbursts, myself and two colleagues transferred Mr C from a toilet chair to his daychair. I lent over to undo the lifting belt from his waist and he lashed out with his arm connecting with my jaw. I caught his arm by reaction, held onto it, looked him straight in the eye and told him he was not to do that to me again. My colleagues looked horrified and I was unsure if it was due to Mr C's actions or my reaction.

"The anger of where this man is coming from and why he feels he has the right to strike another person; He does have the right to be angry - but not to show it in this manner. I got angry at Mr C and then got angry at myself for being abrupt in manner" (Journal Entry 14.6.95).

There was no putting off the inevitable this morning - I had to ready Mr C for the day by 0930. I felt confident in procedure; no frills, no nonsense and I felt I had met Mr C's needs. I had adopted this attitude prior to arriving at clinical as I felt it would be an unfair burden on my colleagues knowing how they all fear Mr C. To leave him for others would have been very easy but would have been shrugging my responsibilities to Mr C. What I initially felt to be responsibility turned out to have a positive outcome. All day as I passed Mr C's room, I would look at him in passing and smile. When I entered his room for a reason I would smile, little or no words were spoken and I would leave.

"I placed a scrapbook in front of Mr C and commented how a particular picture looked like North Canterbury with the Waimakariri River in the distance - 'not unlike Kaiapoi Mr C.' The look of astonishment on Mr C's

face. I had taken time to find out he was from Kaiapoi. I won't kid myself it was a true grin but it was a faint smile of recognition - perhaps not directed to me but of memories of his past. At that moment there was rapport; it may not be built on and it may not be remembered or recaptured tomorrow, but it was definitely there today" (Journal Entry 16.5.95).

The previous days had been harrowing both physically and mentally and my nursing practice with Mr C was causing havoc with me and my colleagues.

However many feelings, thoughts and emotions and particular rewards had come from this day. My journal entry in relation to the day was directed to 'R' (a colleague) as her words in reflection ring in my ears - "I would like to think about it", was her comment when our tutor directed a question to her in relation to her thoughts on my nursing care for Mr C. A colleague asked me if I was alright, mixed emotions and my own questions stirring within me. She had questioned them for me; R's words made me address them. During reflection our tutor shared a journal entry of his about all of us becoming and being part of a family. I had been feeling the black sheep of our family of late; trying to justify my nursing practice with Mr C to myself and to others. I had entered reflection oblivious to issues discussed in my absence the previous day. I felt questioned by colleagues and had spent the last week questioning myself. Judgements had been made and I felt justification was warranted.

No - I am not fulfilling the role of a nurse as we have been taught in a classroom; I have been 'doing to' a patient rather than entering a 'partnership' with a client.

No - I have not empowered a client giving him options and choices; instead I have coerced a man and his demands to fulfill my needs.

But I maintain I have not imposed my values and beliefs on Mr C as my nursing care of him goes against the grain of my values and respect for the elderly.

I chose this path of nursing practice with Mr C feeling that was the best way to meet his nursing needs and thus respecting him in what he didn't want nor appreciate, i.e., 'fluffing and puffing'. He is angry at the world and everyone in it. I feel he copes with his world by intimidating those in it.

I felt it futile to try and explain and justify my actions in relation to Mr C and words could never express the elation I felt when Mr C asked "Where'd you get to?" when I entered his room after having been to a meeting for an hour. Mr C's question had answered all my self-questioning and voided the need to justify my nursing actions. I wish R had been there - but my client, a man of very few words, had directed this to me and it was probably only to be felt by me.

"I feel it is good to be challenged as it presents questions to be addressed and answered - however, to be judgemental can cause pain and embarrassment in situations not known" (Journal Entry 16.6.95).

I identify with the competency of Benner's 'Helping Role' through my experiences illustrated in my exemplar 'Guiding Patients Through Emotional and Developmental Change: Providing New Options, Closing Off One Ones: Channelling, Teaching, Mediating.'

Benner states that the nurse, acting as a guide and mediator helping confused people carve a path into a more shared, less idiosyncratic world, is firm, direct and approaches the patient with as much clarity as possible. In trying to help people change, the nurse acts as a psychological and cultural mediator (Benner 1984).

At my level of nursing practice, I do not feel that I was aware of trying to help Mr C to change - to be honest, I initially wanted to be able to care for him in his activities of daily living without a verbal or physical outburst. However, a change did occur when I changed my nursing practice to fulfill his needs - by being firm and direct with him.

My approach with Mr C was to use simple statements/directives that would not confuse him and that he could understand.

I will not pretend to fully understand his behaviour and outbursts, but I did learn and remember the 'patterns and scenarios' in order to anticipate Mr C's response to something (Benner 1984).

Reflecting on these experiences and reading entries in my journal I began to wonder if nursing practice is a learning or growth process. I feel the advancement of both. Growing and learning by experience provides room for more growth.

My experiences with Mr C provided many challenges. I grew from initial fear and intimidation of a difficult man to anger towards his behaviour. I then had to address personal issues based on my values and beliefs in relation to an elderly confused man.

In the beginning the tutor had to take control of the situation because I had assumed expected behaviour whereas in my advancement of nursing practice and by accepting Mr C's behaviour I was able to take control of the situation. Through respecting Mr C for who he was, I was able to choose and adapt my nursing practice to best meet his needs. We set boundaries for one another and from these boundaries came an acceptance of each other.

These experiences have provided a growth/learning process for me and I feel I have identified how they have contributed to the advancement in my nursing practice.

References

Benner, P. (1984). From Novice to Expert: Excellence and Power in Clinical Nursing Practice. California: Addison-Wesley.

This exemplar won the Gerontology Association's prize.

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Beginning Journeys - Volume 2

Exemplar From Practice

Catherine Rietveld, Plunket Nurse

In December 1977 I graduated as a Registered Comprehensive Nurse from Christchurch Polytechnic, (formerly Christchurch Technical Institute). I spent the following 15 months consolidating my learning at Princess Margaret Hospital in Medical/Surgical and Psychiatric wards.

In 1979 I completed the Midwifery Training programme at Christchurch Women's Hospital. After working in a postnatal ward for a few months I left to have my first child in 1980. In 1981 I returned to the workforce and spent the next ten years as a midwife on night duty.

With the changes in legislation affecting the delivery of midwifery service I welcomed the opportunity to provide follow up postnatal care to families at home. This is when I recognised my desire to be community based. To become a fully fledged independent midwife would not have been compatible with the needs of my family (children now numbering four).

In July 1995 I was accepted onto the staff of the Royal New Zealand Plunket Society as a Pre-Certified Plunket nurse. In April of this year I began Plunket Nurse training and look forward to completing in October and graduating in December.

Background Information

Sixteen year old Jenny gave birth to Michael on New Years Eve and it seemed to her that the whole world was rejoicing. Jenny has now turned 17 and is an unsupported solo parent. She left school without finishing her studies to have her baby.

For the first five weeks, Jenny's life as a new mum was quite exciting. School friends had been visiting and they seemed envious of Jenny which made her feel understandably proud. Michael was growing and developing well and Jenny was becoming more confident with her parenting skills.

During my first visit we talked about a lot of things to do with parenting and her ability to cope with the enormous change to her life. Prior to giving birth she had been living with her father out of town. Now that the baby was born, her family seemed to think it was best for her to go flatting, (I suspect that the reasons were related to finances as she was not eligible for the Domestic Services Benefit, [DPB]).

Jenny was now sharing a flat with two other people and all appeared to be going well. The flat was "state owned" and in desperate need of maintenance. There were no carpets and instead of drapes, blankets hung saggily across the windows affording some privacy.

The bridge that crossed the stream in front of the flat had loose boards that appeared to be rotting. I made a mental note to discuss this with Jenny and to encourage her to bring it to the attention of the landlord.

In view of her youth and lack of support, we decided that a referral to an extra care and support agency would be appropriate. With extra agency contact I was confident that Jenny's needs would be met so I left her with a return appointment for two weeks.

The Event

On my return two weeks later I found both Jenny and Michael in a very sorry state. It was 2.30 pm on a Friday and Jenny was extremely unwell with a gastric "flu". She looked ghastly, pale and drawn, and she was holding her stomach as though in pain. I asked her if she had seen a doctor, to which she replied, "No, I've got no money and no transport." She was using a central city doctor who gave free consultations but had no taxi fare to get there.

It was obvious to me that she was in no position to care for herself or her child. The house was filthy, there was half eaten food and dirty nappies lying around and dozens of flies having a field day!

I sat down and talked to Jenny for a while in an effort to assess the situation and together arrive at a solution that would meet her immediate needs. The scenario that unfolded caused me a great deal of concern.

Jenny had come into conflict with her flatmates over Michael's crying. Michael's father had tried on several occasions to gain entry to their house in a drunken state and he had also been verbally abusive. Jenny was fearful for her safety as her former partner had been physically violent with her in the past. These problems resulted in the flatmates moving out leaving Jenny alone.

The phone had been disconnected because the account was $200 in arrears. Jenny had no money to clear the arrears and only part of the account was her responsibility.

The rent for the flat was $150 per week. Jenny's income per week from the Emergency Maintenance Allowance was $120 leaving her a short fall of $30. As she was only 17 years old she did not qualify for the DPB. She had not been able to pay the rent since her flatmates had moved out as she had to spend her money on power and groceries. She was now worried that she would be evicted.

Michael was sleeping erratically and Jenny did not think he was very well. My assessment showed he had enlarged cervical nodes and had not gained weight in two weeks. His skin turgor was good, his abdomen round and soft and his anterior fontanelle was not sunken. He was still having plenty of wet nappies but his bowel motions were looser than normal. His eyes were wide, he was crying hard and he appeared to be very hungry.

Jenny was breastfeeding but felt that her supply had dropped off since becoming ill. Jenny had been giving him some supplementary formula feeds. At this point she told me she had no milk powder left.

I was very concerned about Jenny and Michael and decided (together with Jenny) that a plan for the weekend was needed. At this point I had to leave Jenny and go to the clinic to use the telephone.

I tried to contact:

- her mother - no reply
- her extra care and support worker - no reply
- my Area Manager - not available
- Plunket Karitane Family Centre - suggested I phone Catholic Social Services or the Home and Family Society
- Catholic Social Services - no reply
- Home and Family Centre suggested I call Pregnancy Help
- Pregnancy Help - at last some action. I arranged emergency weekend accommodation with a volunteer who just happened to be a midwife (I checked with Jenny to make sure that the arrangements suited her).

Jenny's face lit up when I told her of the arrangements. As Jenny had no transport I would have to take her to the volunteer caregiver. Then the next little challenge presented itself. No car seat! Fortunately her neighbour was also a client of mine and very kindly loaned me hers. By this time it was about 4.30 pm and as I had other appointments to keep I bundled mother and baby and a few belongings into the car and delivered them both into the safe keeping of the volunteer.

This saga continued well into the next week but for the purposes of reflective learning I will not go into any more detail.

The Significance

The incident was significant to me because it represented an incredibly steep learning curve at the beginning of my career as a Plunket Nurse. At the same time it highlighted some very common health and welfare issues.

1/ Always on a Friday!

Is it just part of Murphy's Law that these challenges so frequently present late on Friday afternoon? Or is there some more scientifically explainable causative factor?

2/ Insufficient Self Help Health Care Skills

I do not believe that Jenny has the confidence or competence to keep herself and her child well. Some of this will of course have been influenced by her lack of finances. She needs practical guidance in basic family and home management.

3/ Inappropriate Medical Choices

Although Jenny had accessed "free medical consultations" the location of this service in relation to where she lived makes it an inappropriate choice. This is something that I should have noticed and made suggestions about at the initial visit. After consulting with my colleagues I now realise that my own deficiencies in community knowledge stood in the way of accessing this free medical care. (I am now aware of agencies that provide transport in such situations.)

4/ How do we encourage people to care for each other?

Perhaps this notion is rather idealistic, but where was the accountability of her flatmates? How could they walk out and leave her holding the baby? Somehow as a culture we need to redevelop a caring attitude towards each other. This brings us back to the premise that we can only nurture if we have first been nurtured.

5/ An inequitable financial predicament

Budgeting on a benefit is tricky enough at the best of times and made even more difficult when other variables such as sickness are thrown into the equation. In order to qualify for the DPB you must be aged 18 years or over. The Emergency Maintenance Allowance is paid to 16 and 17 year old mothers plus additional benefits payable depending on the situation. (Ref NZISS pamphlet Domestic purposes (6) July 1996). Teenage mothers who are under 16 years of age are assessed by the Children and Young Persons Service. Income Support were very helpful and after reassessment they were able to adjust her benefit to meet her needs.

6/ Early intervention not early enough

Had there been more efficient intervention earlier, or had Jenny been confident to refer herself, this cumulative crisis may have been avoided. As a group of health professionals across all agencies we have the knowledge to effect change in health but sadly we lack the human resources to be truly effective.

7/ Plunket Karitane Family Centre to the rescue!

I find it a most interesting observation that the only agency that responded to my call for help was the Plunket Karitane Family Centre! I know this is not an isolated incident, perhaps a register of such contacts should be kept by Plunket nurses to support the need for their ongoing services to families.

8 /Volunteer provides help

Yet another interesting observation in this age of a fiscally driven user pays health service. A volunteer picks up the tab. Where on earth would New Zealand be without its band of volunteers? Really HOW MUCH MORE CAN WE ASK BEFORE THE BOUGH BREAKS AND THE CRADLE COMES CRASHING DOWN!

My major concern at the time was the compromised health of Jenny and Michael. They needed supervision over the weekend as their situation was in danger of deteriorating. I did not feel that she was safe for the weekend with no phone and no transport.

At the time all this was happening I was thinking of my own family. My own daughter is only 18 months younger than Jenny. My own mothering instincts were very strong and I nearly offered her a bed at my home for the weekend. However, I knew I had to be cautious of setting a precedent.

The most demanding factor I found in this incident was that Christchurch seems to shut down at 3.00 pm on Friday. None of the "normal" help channels were answering their phones. I can only say thank you to the Plunket Karitane Family Centre and the fantastic Plunket and Karitane nurses whose community health nursing knowledge led to a health gain for Jenny and Michael.

The most satisfying factor in the situation was that on this particular day I had the time and the resources to respond to Jenny and Michael's needs and that I could go home for the weekend confident that it had been a crisis managed to the best of my ability.

It is exactly this sort of situation that Plunket nurses encounter daily. It heavily endorses Helen Wilson's observations in her editorial published in the April edition of Kai Tiaki.

As a woman, mother and nurse I am determined to strive for the betterment of maternal/well child health in New Zealand so that once again we as a nation can be proud of our maternal and child health statistics. The million dollar question of "HOW?" remains, but I am confident that in my development as a child health practitioner/community health nurse, avenues for action will open.

The true names of mother and baby have been changed to protect their identity.

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Beginning Journeys - Volume 2

Ode to Drinking

Loren Young, Elizabeth Walker, Anna Lumsden, Felicity McIntyre, Bachelor of Nursing Students

Pissed as a fart
Off your face
Drunk as a skunk
A social disgrace.

Brain cells dying
Destroying your health
Quickly run to the toilet
Calling out for Ralph.

Crawl into a corner
Wallowing in your sick
Everyone's staring
Yelling "Spot the dick".

Wake up in the morning
Headache from hell
Trying to remember last night
And not doing very well.

Look at the alarm clock
Look for the wife
Oh no what have I done
I'm ruining my life.

I'm late for work again
My wife and kids have fled
My boss is going to kill me
What a screwed up life I've led.

My self esteem is low
I've got no friends anymore
I need some help quick
Please someone show me the right door.

This poem was written as part of class work on lifestyles.

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Beginning Journeys - Volume 2

A Second Year Staff Nurse's Perception of the Horizontal Violence in Nursing

Anonymous, Bachelor of Nursing (Transition) Student

Sideways violence, anger, oppression,
caused me aggression
Open your eyes, can't you see,
I'm on your side, not the enemy
Why are you scared?
Why do you fight,
you are the one that holds the light.

Get out of my space,
you're in my face, a major disgrace to the nursing race
Us few who are new, we show some life,
but you seem intent to cause us strife
I do my job and I do it well,
but I get no praise, just a voodoo spell.

I'm older and wiser and been there before,
I can handle the shit that you throw at my door
The one's who are young, fresh and new,
you like to crush them under your shoe
So hear this now, listen to what's been said,
for I am alive and you are dead.

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Beginning Journeys - Volume 2

Nursing Research Conference 1995

Jaana Lusher, Bachelor of Nursing Student

Last year I was fortunate enough to be one of three nursing students who gained a sponsorship to attend the 22nd anniversary, New Zealand Nurses Organisation (NZNO) Nursing Research Section Conference. This took place from 23-25 November at Massey University, Palmerston North.

The focus of the conference was "The Art of the Possible - Advanced Nursing Practice". Nurses have a huge capacity to create communities of care by responding to the present reality - the conditions, challenges and uncertainties. Research is the dynamic link between education and practice. By translating ideas into significant and effective actions, new and exciting possibilities can open up, from which everyone benefits.

I had some reservations about attending such a conference. I knew that everyone there would know so much more than myself. Being a "novice" in a room of "experts", I was afraid of having nothing to contribute. My fears were unnecessary, and I soon realised that by simply attending we were making a contribution. Other participants were thrilled by our attendance as the only students still studying in an undergraduate nursing course.

The conference keynote speaker was Linda Baumann, Associate Professor of the University of Wisconsin - Madison School of Nursing. Judith Christensen also attended on the third day to present the keynote address. I do not have the opportunity here to explain about each speaker, so I will briefly outline one presentation from each of the three days.

Day One

"The threads woven between education and practice through research: a new graduates perspective", Donna Frost

It was particularly inspiring and relevant to hear from someone who graduated only one year ago, and is already involved in active research. Donna talked about how the road for new graduates from "novice" to "expert" is a long one, but links can be made between education and nursing practice. Through the utilisation and participation in research, nurses are encouraged to reflect and improve upon their practice.

Donna has been involved in a small research project concerning constipation in the elderly. She acknowledged the benefit of working with a motivated team of nurses at Auckland Hospital, who value the contributions of a new graduate. In an environment in which research is not valued, it is easy for new graduates to lose interest in it.

Day Two

"Developing an understanding of women's perception of urinary incontinence: the journey towards continence through emancipatory action research", Lucienne Frey-Hoogworf

Lucienne has performed research which incorporates clients' expertise into nursing practice. The participants developed a support group and undertook conservative treatment plans which led to the regaining of continence for three of the women. The fourth woman showed improvement. Incontinence had been having a negative impact on the participants' lives. It caused embarrassment, anxiety, decreased self-esteem and meant that many had given up activities.

It was really encouraging to hear how some quality nursing input had such a positive effect. This brought into focus the very real benefits nurses can make in improving the health and lifestyles of individual people. Even if on a smaller scale, nurses are vital in education and increasing public awareness.

Day Three

"Becoming an advanced nurse practitioner", Judith Christensen

This was a wonderful opportunity to hear from a woman I'd heard so much about! Judith's discussion included how nursing needs to move away from a "paradigm of warfare" characterised by defensiveness, oppression and isolation. Nursing is, and always has been, inherently unstable as a separate entity. With the development of pathways to "advancement" in practice, nurses have the challenge of more accurately defining nursing roles and practice. Movement is needed to a paradigm of community with blurred, even dissolved, disciplinary boundaries.

Attending the conference helped put the value of research in a new light for me. By presenting real life issues for nurses and clients, it was shown how an improvement in care could be recognised and acted upon. By gaining a greater understanding of the client's perspective, research motivates nurses to reflect on their practice, challenge their perceptions and actively work at improving the care they give.

I also found it inspiring to meet people who were so passionate about improving their work and that of other nurses. The realm of development in nursing is endless, and I felt more than ever that I always want to extend on my practice. Nursing can be so much more than a "40 hour a week" job which you go to, do the work, then leave. As quoted by Margaret Idour, chairperson of the conference, "The purpose of nursing may remain constant: but the practice of nursing must change as required to retain relevancy to the context of need."

Aside from the academic component, attending the conference gave the opportunity for even further insight. It was interesting to hear how tutors actually joke about their students as much as students joke about the tutors! The food provided for us was absolutely incredible, and was consumed in great quantities. It was also good to look around the Massey University campus through which some of us may do our Masters or other courses. We each assumed that it would be a wonderfully social place to live and study.

Two of our tutors, Lynette Low and Jackie Walker, also attended the conference. This provided a chance to get to know them on a more personal level. I greatly appreciated their company and support.

I'd especially like to thank the Nursing and Polytechnic Research Committees and the Christchurch Polytechnic Students Association for their generous level of sponsorship. I encourage other students to take advantage of future opportunities such as this, even if funding is not available. I'm sure that it would be money well spent. I feel lucky that I could attend the conference and am sure it can only benefit my nursing practice.

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Beginning Journeys - Volume 2

Te Hui O Nga Maori Tauira Nehi 1996

Maraea Henderson, Bachelor of Nursing Student

Introduction

This Hui was held for all Maori nursing students throughout New Zealand. It is an annual gathering of Maori students and registered nurses who meet to discuss issues relating to Maori and health. This year it was held in Ratana from Sunday 23 June through to Wednesday morning 26 June. Approximately 300 people attended. This included Nursing tutors and Kaumatua.

Programme

The Hui was held over three days. Time spent in lectures and workshops was in excess of forty hours. These continued well into the evenings.

Sunday

The first day involved registration, introductions, church services and the history of Ratana.

Monday

There were three main kaikorero (lectures):

1. Where to from here for Maori Nurses - Whaea Putiputi O'Brien, Patroness NCMN.
2. Maori Mental Health: The Effects of Colonisation - Dr Moana Jackson.
3. Mental Health: The Illnesses that Affect Maori People - Professor Mason Durie.

This was followed by a panel discussion.

In the evening we attended workshops. The topics included:

- Preparing kai and associated tikanga
- Men: Their responsibilities and attitude towards women
- Suicide
- Smoking and alcohol abuse
- Massage for health and mind
- Working with harakeke (flax)

Tuesday

The main focus was the student forum where students could raise concerns and discuss issues relating to Maori people and their health. They could also discuss issues relating to specific institutions. The purpose of this was to set up a support network.

Highlights

The highlight for me was attending a Kaikarero presented by Professor Mason Durie as I have been using a textbook written by him all year. His teachings were made more relevant and understandable by hearing him present them personally.

It was also a privilege to hear Dr Moana Jackson. He used humour and was easy to relate to as a person.

Conclusion

As Maori nurses we need to understand why our people have such poor health in relation to other groups. Through a forum like this we can set up communication networks and support where we can begin to address health issues. For example, the high numbers of Maori with psychiatric illnesses and low self-esteem.

This was a very valuable experience. It affirmed the knowledge I had acquired in the Treaty Education course and reaffirmed for me the effects of colonisation and causes of poor Maori health. I have to express disappointment at the lack of preparation, organisation and direction from some participants.

Recommendations

- That representatives from Christchurch Polytechnic continue to attend this national Hui.
- That the group takes responsibility itself to prepare for the Hui and organise the contributions and fundraising events, including koha, for the 1997 Hui in Auckland.
- That all participants attend workshops.
- Travel arrangements for Kaumatua and Kuia be organised before departure from Christchurch, e.g., taxi chits.
- That each participant give a written report on the Hui to the Faculty of Health and Sciences.
- If a participant cannot commit fully to the Hui programme, then they should not participate at all.

Acknowledgements

I would like to record my appreciation to the Faculty of Health and Sciences for their generosity in providing the funding which allowed students from Christchurch Polytechnic to attend.

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Beginning Journeys - Volume 2

Report on 1995 Research Activities

Cathy Andrew RCpN, BA, Research Leader 1995

Implementation of Stage 3 & 4 of the Bachelor of Nursing and the winding down of the Diploma programme have created another busy year for staff. The research team structure with three teams has continued. The Departmental Research Committee has met approximately monthly throughout the year. A decision to change the structure in 1996 has been made with the departmental committee to co-ordinate combined meetings on a regular basis for all teaching staff.

Research Activities

Four Network Meetings

- Dr Cheryl Benn - Antenatal Care Utilisation and Perinatal Outcomes
- Dr Jan Rodgers - Paradox of Power and Marginality - An Historical Investigation of Nursing and Midwifery
- Dr Val Fleming - Research Using Critical Social Theory - Wanganui Waterbirth Study
- Dr Judith Christensen - The Nursing Partnership Model

Regular Meetings of Research Teams

Teaching & Learning Team Report

The decision was made early in 1995 that this team would meet as necessary only due to the high level of commitment the members had towards university work. The team therefore met three times. The outcome of these meetings was a contribution to the Departmental Research publication on "Learning Contracts" and the organising and contributing to a Research Feedback Day."

This day gave team members the opportunity to share the research work undertaken through the year with interested students and staff.

Lynette Low

Health Issues Team

During 1995 I was co-ordinator of the Health Issues Research Team. We met approximately seven times during the year with numbers attending ranging from two through to seven people. A portion of these meetings was dedicated to hearing what scholarly activities each of us were up to. It was from these informal presentations that a few of us, with the support of the other members, put forward a series of abstracts for publication in the inaurgaral departmental journal. Following this the group discussed and agreed on publishing a paper in Kai Tiaki : Nursing New Zealand in 1996. Around the same time it was decided to alter the departmental research structure. Our plans for future publication as a group have been postponed.

Personally I believe our team to have worked well together and had a commitment to the growth and development of a research climate in the department. I really appreciated the motivation and enthusiasm brought to the meetings by the members particularly in light of high teaching and personal study commitments.

Stephen Neville

Departmental Research Meetings

- Post Easter Staff Development Day - Presentations by staff of University research projects completed last year
- Staff Debate - critical thinking - how do we represent what we expect from students
- Research Reports - presentations to staff and students by staff who have conducted research projects this year.

Midwifery students research project presentations

Two departmental representatives on Academic Board Research CommitteeNZNO Research Conference

Two staff attended NZNO Research Conference. Sponsorship was also obtained from Polytechnic Research Committee, Students Association and Department for three students to attend conference.

Research Projects

Cathy Andrew - MA Thesis (in progress)
"Nursing the families of patients who die in Intensive Care."

Debbie Gillon - *"Attitudes of Student Nurses Towards the Elderly"*
Approved to start February 1996

Elizabeth Griffin - M.Ed
"Changing perception of self through the experience of disability : A qualitative case study."

Lynette Low - M.Ed
Evaluating the impact of different teaching philosophies on how students of nursing approach learning and their perceptions of the course.

Qualitative research *"exploring the perceptions of what "nursing informatics" means from the perspectives of a tutor in the subject and a students in the class".*

" A superb plan to keep everything in order." Exploring the lived experiences of a nurse in Aotearoa/New Zealand 1945-1970.

Daphne Manderson - Ph.D Topic
"To explore the subjective experience of grief and loss with women who have experienced the death of their mother and to gain a greater understanding of wonen's experience of grief from the daughter's perspective."

Kaye Milligan - Diploma of Tertiary Teaching
"The practice of physical assessment skills by nursing students and factors which help hinder their practice."

Pauline Peterson - *"Advancing Nursing Practice through Health Assessment"* (in progress)

Beverley Rayna - Ph.D Topic
"A sociological analysis of how nurses use networks to structure their careers."

Cynthia Stokes - M.Ed
"Nursing Students' Experiences of Journalling."

Jackie Walker - M.Ed
"Learning Physical Assessment Skills : A student's perspective."

Rayna Wootton - Ph.D Topic
"The experience of older persons having surgery and their experience of recovery."

Papers Presented

Ann Blackie - *"The impact of the current social and health reforms on careers in nursing education"*
NZNO NERF Scholar Day, Christchurch

Stephen Neville - *"Story telling: A perspective on oral traditions in New Zealand"*
International Paediatric Nursing Conference, Auckland

Mary Wade - *"Professionhood - Fostering Quality Practice"*
Consensus Conference, Auckland

Jackie Walker - *"Teaching Psychomotor Skills : Is Kolb's experiential learning cycle effective"*
NZNO Research Conference, Palmerston North

Ray Wootton - *Opening address*
NZNO Research Conference, Palmerston North

Workshop Facilitation

Cathy Andrew - *"Ethics in Nursing Education"*
Nursing Ethics Day, Canterbury Health

Anne Morgan - *"Caring for Ourselves"*
Oncology Nurses' Conference, Palmerston North

Publications 1995

Daphne Manderson - (joint Author) *"Dealing with Dying"*
Kai Tiaki Nursing New Zealand, 1 (4), 13-16

Stephen Neville - *"Family Nursing : A case for a nurse consultant"*
Nursing Praxis in New Zealand, 10 (2), 24-28

Department of Nursing, Midwifery and Health Education Journal (Issue One) "Beginning Journeys..."

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