Beginning Journeys - Volume 5

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Beginning Journeys - Volume 5

Guest Editorial

Stephen Neville, RCpN, BA, MA (Hons), FCNA (NZ) - Research Leader

Nursing research plays a key role in examining the approaches and techniques that influence nursing practice as well as giving credibility to new nursing procedures and practices. It is therefore important that research outcomes are readily available to all nurses, no matter where they are working, in a format and language that is user friendly. In Aotearoa nursing research continues to primarily be linked to higher tertiary education, for example masters or doctoral study. Although the research outcomes related to participation in postgraduate study are valued, useable and in many instances a relevant contribution to nursing knowledge development there is still not enough nursing research being undertaken. Maybe this is a developmental issue, which will change over time.

A significant portion of published New Zealand nursing research positions itself under the auspices of qualitative research with significantly less studies utilising quantitative methodology. Unfortunately the key players influencing the distribution of research funding tend to give preference to quantitative and not qualitative research. This issue is a dilemma for nursing that has yet to be solved, although the Health Research Council of New Zealand has made provisions in its funding criteria to accommodate qualitative methodologies (Ministerial Taskforce on Nursing, 1998).

The Health Research Committee, Faculty of Health and Sciences Christchurch Polytechnic has experienced a philosophical shift in the way nursing research is viewed within the Faculty. We began by stating that our role was to develop a research culture. In 1999 we now claim to be supporting a research culture. Beginning journeys A collection of work fits within either position. The annual publication of the journal mentors people new to research and scholarly activities to take the step and publish their work and it is also a vehicle to disseminate knowledge related to health and education. The journal is available in hard copy and also appears on the Christchurch Polytechnic website.

It gives me great pleasure to present the fifth volume of Beginning journeys A collection of work for your perusal. Happy reading.

Reference

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CHRISTCHURCH POLYTECHNIC INSTITUTE OF TECHNOLOGY Te Wānanga o Ōtautahi New Zealand

Intuition & Nursing

Michelle Parkes - Transition to Degree Nursing Student, Christchurch Polytechnic

Introduction

A theme which has recurred in my weekly journalling is intuition. This article will explore current literature and theories which examine different types of intuition discernible in nursing practice.

Intuition as a way of knowing, within Carper's model (1978, as cited in Johns 1995a) will be examined as will the development of intuition within Benner and Tanner's (1987) five levels of skill proficiency. Dreyfus's (1979, as cited in Paterson, 1990) six aspects of intuitive judgement will also be highlighted. Examples from my journal entries will demonstrate theoretical links between these.

Intuitive intelligence is fascinating because it has been reduced in relevance by the technical rationality of the biomedical health model. Yet health professionals use intuitive skills every day. These skills enable us to "understand, to speak, and to cope skilfully with our everyday environment" (Dreyfus & Dreyfus, 1985, p.xx).

Intuition

Intuition is a nebulous form of knowledge which has largely been dismissed as it cannot be explained or observed easily (Johns, 1995b). Definitions of intuition vary among theorists.

Edmund Husserl (1859-1938) was the father of the phenomenological movement in Germany. This movement sought to interpret the inner spiritual and cognitive understandings of humans. Husserl's term for phenomenology was *intuiting* which refers to "logical insight based on careful consideration of representative examples: it is not second sight or inspiration" (Wilkes, 1991, p.233). Yet Assagioli (1977, as cited in Rew, 1988, p.150) identifies it as a "higher form of vision."

Mitchell (1994, as cited in Darling, 1995, p.16) says that intuition is "the power of gaining knowledge without rational thought." This understanding without reasoning appears to be the most prevalent definition among modern writers. Schraeder and Fischer (1986, p.161) also say intuition is "the immediate knowing of something without the conscious use of reason."

There is, however, agreement on some prime aspects of intuition. The awareness is immediate and is a "knowing in action" (Lumby, 1991, p.467). It is common to all people, so is "a universal characteristic of human thought . . ." (Bastrick, 1982, as cited in Rew, 1988, p.150). It is often expressed in global terms as a *feeling* or *knowing* and it is not in conflict with analytical reasoning. Jung (as cited in Schraeder & Fischer, 1986, p.1) summed up these last two points by stressing that "intuition is another dimension of knowing and is not in opposition to deductive or inductive reasoning". Intuition and analytical reasoning often work together (Benner & Tanner, 1987).

Any intuition which is not based on analytical reasoning is not given credibility in the scientific, biomedical health paradigm (Rew, 1988). Yet this form of knowing is valuable. If nurses give it no value and ignore it, it is detrimental to the patients (Darling, 1995). Using it, nurses can rapidly make decisions by recognising the underlying significance of patient-related problems (Rew, 1988). This knowledge, combined with rational analysis, is the most appropriate method of reasoning for the nursing process (Paterson & Zderad, as cited in Rew). Intuition is "a hallmark of nursing knowledge . . ." (Rew & Barlow, 1987, as cited in Rew, p.150). So it must be recorded and researched.

Types of Intuition

Rew (1988) discusses three types of intuition outlined by Loye (1983) which are used by nurses. *Cognitive inference* occurs when conclusions are determined spontaneously and the nurse is not aware of conscious reasoning. I have discovered that as a practice nurse I use this intuition frequently.

Mrs D was sent around by the receptionist to be seen immediately. I saw a trail of copious amounts of blood dripping behind her as I led her into a room. It was coming from her leg, and her foot and sandal were soaked in blood. I immediately got her up onto the bed with her foot elevated on the pillow folded in half. As I was undoing her dressing she explained that she had had an oozing ulcer and that it hadn't stopped all day. Without calling in the doctor I quickly wrapped a towel around it and a very tight crepe bandage.

(Personal journal entry)

> In this situation I was not aware of consciously reaching the conclusion that I must prioritise elevating her leg and applying a pressure bandage to stop the bleeding. I just automatically did it. I remember being surprised at myself for ignoring the mess the blood was making until

> I had dealt with stopping the bleeding.
>
> Loye's (1983, as cited in Rew, 1988) second type of intuition is *Gestalt intuition* where nurses can pick up subtle cues and rapidly fill the gaps with missing information. They subconsciously recognise a pattern within a familiar context, and they know what the outcome will be.
>
> Mr K walked in with a friend supporting him. He held his arm diagonally across his chest and was supporting his elbow with his other hand. He was bent over slightly and his facial expression showed a lot of pain. I knew immediately that he had a fractured collarbone.

(Personal journal entry)

> Without taking a verbal history I recognised the visual appearance or pattern presented by a patient with a fractured collarbone. The realisation was an immediate flash in the first few seconds that I saw him. Gestalt intuition is invaluable to nurses when they recognise a departure from the normal patterns which may indicate a problem with a patient.
>
> Loye's (1983, as cited in Rew, 1988) third type of intuition is *precognitive intuition* which is having a feeling or knowing about a future happening which is not based in knowledge about the past or present. This is reported a lot less by nurses perhaps because they feel it will be discounted because it is unscientific (Rew). I have felt this intuition when I have had a hunch that the clinic is going to be busy later and it usually is. However, this may be because I subconsciously recognise that the throughput of patients is low compared to usual which is more like Gestalt intuition.

Carper's Four Ways of Knowing

With praxis and reflection nurses can make sense of their practice through many ways of knowing. This epistemological knowledge was described by Carper as being aesthetic, personal, ethical and empirical (Johns, 1995a). Realistically, nursing knowledge and practice can't be compartmentalised as it is all interactive and interrelated within practice. But for the learning practitioner this may provide a guide to the question they need to ask themselves about their practice and it does give relevance to other sciences apart from empirical science. Johns (p.230) acknowledges that Carper described the above ways of knowing as "discrete but interrelated."

Johns (1995a, p.228) describes the *aesthetic* way of knowing as the "intuitive grasp of and response to a clinical situation." The following example of aesthetic knowledge allowed me to cohesively coordinate many facts of *empirical* or systematical organised ways of knowing. These are wound care, steristripping, use of instruments and solutions, and knowledge of aftercare and advice. Aesthetic knowledge orchestrates the others ways of knowing so that I ultimately make the right decisions and can do many things at once. It facilitates the consideration of the *ethical* ways of knowing. These can be encompassed within the conflicts based on past experience, of steristripping versus stitching. Intuition facilitates the *personal* way of knowing where I continue to care for and relate to S and her mother, despite the conflicts.

Journal Entry: The Aesthetic Way of Knowing

Nine year old S had walked into a tree when talking to her friend and had cut her top lip and bumped her forehead. Her lip was cut inside from her teeth and her face was grazed at the side. The main concern was the upside down V-shaped cut above her top lip which was a small but deep flap which had bled profusely.

The doctor asked me to clean it out as it had bits of macrocarpa in it and to steristrip it. I often dealt with wounds and steristripping but this one I felt quite concerned about as it was in the middle of a young girl's face and could scar. It was either steristrip it or stitch it. Often the trauma of needles and stitches in areas where the child is going to move is weighed up against what would be the most effective method. A tricky one! The steristrips are good because there is less scarring if they pull the areas together well. But I was worried about the tip of the flap not staying in place with the movement of her lip when she was eating and talking.

She cried, but tried to stay still and said that it hurt a lot as I tried to clean it with gauze wrapped to a point around forceps and then picked the tiny pieces of bark out. Her mother was asking about the other graze on her face, the cut in her mouth, and the bump on her head. So I gave her advice on saline mouthwashes, putting ointment on the graze to keep it moist and the symptoms to watch for in case of a head injury. I recommended that S have an iceblock afterwards to keep the swelling down on her lip.

I thought afterwards this really is a skilled job, having the knowledge and ability to give this advice, while dealing with a distraught child and concentrating on fine work at the same time.

I managed to stick the strips on, with the help of friars balsam, pulling the edges towards each other with four small strips, but it was extremely difficult under her nose. I was wondering if she really should have seen a plastic surgeon.

Benner's Five Levels of Skills Proficiency

Aesthetic ways of knowing or intuition usually develop as a nurse becomes more experienced. Benner

(1992) describes the progression in nursing from *novice,* to an *advanced beginner* stage to a *competent* stage, to a *proficient* stage, to an *expert* stage. This was based on the Dreyfus model of skills acquisition developed by brothers Dreyfus and Dreyfus as they felt artificial intelligence, for example computer programmes, were limited when it came to "commonsense understanding" (Paterson, 1991, p.7).

As nurses acquire skills their thinking moves from reliance on abstract rules to reliance on past concrete experiences. It shifts from rule based analysis to intuition. Their perception changes from perceiving parts of a situation to the whole situation (Benner, 1992). Warelow (1997, p.1022) states that when nurses become experts and practice using intuition their "theory, practice and experienced wisdom . . ." work in harmony.

Dreyfus's Six Key Aspects of Intuitive Judgement

There are six main ways in which intuitive insights are gained, as outlined by Benner and Tanner (Paterson, 1991). The first way is *pattern recognition.* This is where relationships between a group of features within a certain context are perceived as a recognisable pattern. To illustrate, I can usually tell how long a wound or ulcer is going to take to heal by the way it looks before analysing the different aspects of the ulcer.

I could tell immediately that the ulcer was likely to heal quickly by the way it looked. It was much smaller, less sloughy and less red around it than a week ago. In comparison to some of the ulcers I'd dressed over the years this one was improving and not static. It had new granulations around the edge closing in.

(Personal journal entry)

This reflection also demonstrates the second key aspect of intuitive judgement which is *similarity recognition*. Despite the ulcer being on a different person's leg, the healing was similar to ulcers I'd seen previously and I recognised the healing features and process. In the next example I initially thought that I experienced recognitive intuition but on reflection saw features that the situation had in common with others, making it more like similarity recognition.

Journal Entry: Similarity Recognition

L aged 21 was referred to me for a blood test after seeing the doctor. I introduced myself, offered him a seat, and asked him if he'd had a blood test before. He said no, but that he was okay and felt fine about it. I asked him if he would like to lie down on the bed as I had a feeling it would be better for him. He said that he would be alright sitting in the chair.

I commenced the test, explaining everything as I went, still feeling that I'd have to keep an eye on him and sure enough, he started to feel faint as soon as he saw the blood going into the vacutainer. I had to quickly finish the test and get him to put his head between his knees until he felt less faint. As soon as he sat up the colour drained from his face again and I had to assist him onto the bed. He stayed there for about 15 minutes and had a drink of water.

Afterwards I said to the other nurses, "I knew that he was going to faint." I had a premonition that he would pass out and wouldn't be safe on the chair. It has happened to me before and every time I have known that the patient would have been better off on the bed and, in fact, have offered them the opportunity.

There are few little signals that have been common to all these situations. The age usually adolescent; the sex usually male; their colour wan or pale, probably due to their underlying condition, and either they tell me that they dislike blood tests, or it is their first time.

The third key aspect of intuitive insight is *commonsense understanding* which is an understanding of the culture, language and the illness experience. This I use when I try to perceive how a patient is going to cope at home with a disabling injury.

Mr K had cut his right hand on the blades of a model aeroplane causing large irregular cuts across his right thumb and three fingers I asked him how he was going to manage at home. He didn't know how as he was right-handed and he lived by himself. The bandage over most of his hand needed to be kept dry and he needed to rest his hand. I suggested that he got in touch with his local ACC branch, hoping that they would arrange some homehelp for him to assist with meals and housework.

(Personal journal entry)

Skilledknowhow is the fourth intuitive insight which is where one's body can carry out the task without consciously thinking, called "embodied intelligence" (Paterson, 1991, p.14). When I now do an electrocardiogram, or take blood, my actions are fluid, whereas I used to have to do these tasks step by step. This is demonstrated in the following exemplar.

Journal Entry: Skilled-know-how

Mr A needed a blood test. I took him into a room where he sat down. I could tell by his serious expression and his bowed posture that this was not a favourite activity of his. He actually said, "I would prefer to be somewhere else at the moment."

I told him I would be as quick as possible and that it only hurt when the needle first went in. I told him that he had easy veins for drawing out blood, so it wouldn't be a problem. As we were talking I positioned his arm down a pillow, put on a tourniquet and checked where the best vein was. I asked him to look away if he

wanted, swabbed his arm, telling him it would be cold, and I was quickly going to insert the needle. When it was in his vein I released the tourniquet, waited for the tube to fill and changed it for another two vacuutainers, while supporting the needle, ensuring that it stayed in his vein. Then I pressed his arm with a cottonwool swab as I withdrew the needle.

He was pleased that it was over, but sat there agitating to go while holding the cottonwool on his arm. I labelled the tubes and put them and the laboratory form in a specimen bag. He was happy to go when the vein had stopped oozing.

I thought afterwards that I used to think about every little step of this process. Even ensuring that you have the right tubes for the particular tests that the doctor wants is a complicated skill. Now, without consciously thinking, I can grab the correct tubes and do the whole procedure without dividing it up into little steps. The whole time I was assessing him as well; his veins to see if they were shallow or deep ones; the tubes to see if they had filled; the needle to ensure that it was still in the correct position; his face to make sure he wasn't going to faint; and his voice and words to see how he was feeling.

The fifth intuitive insight is a *sense of salience* which is where some features stand out in a situation as being more important than others. I find that I am constantly monitoring waiting patients so that I notice any salient features and prioritise treatment, especially for people with eye injuries, chest pain, severe abdominal pain, haemorrhaging, vomiting, migraine, asthma or any erythematous rash.

Lastly, *deliberative nationality* is intuition which compares current situations with situations in the past, considering the different perspectives and interpretations of the situations. A beginning nurse with little past experience would probably not have treated Mrs P the way I did.

Mrs P, over 80 years old, came into the clinic with her daughter, complaining of heartburn. She seemed quite distressed, saying that she had had it for two days. Previous experiences with elderly people and chest pain flashed through my head and I decided to treat her as though she had a heart problem. I helped her up on the bed with the back elevated, gave her oxygen and commenced recordings and ensured that the emergency trolley was nearby. I made sure that she saw the doctor ahead of the other patients.

The Consequences of Nurses Using Intuition

The six intuitive insights are used everyday in nursing. Rew (1988) analysed nurses' responses to intuitive experiences and found that they often used them as a basis for seeking more objective information from the patient, other nurses, doctors or relatives.

Experienced nurses manage to synthesise this objective and subjective data which allows them to make informed decisions quickly. They can consequently cope with rapidly changing situations while still attending to other factors in the environment. Benner (1992) demonstrates an expert nurse still remembering the relatives in a critical care situation. Intuition enables holistic thinking which "grasps the situation as a whole" (Schraeder & Fischer, 1986, p.161).

Nurses who use intuition at the proficient and expert levels develop a strong belief in themselves and their practice and are more prepared to accept challenges (Rew, 1988). They take the risk of not being believed by doctors to whom they report their subjective feelings. Also, they may be constrained by having to have objective data of signs and symptoms before calling in a physician (Rew).

There is justification for more inexperienced nurses to always back up decisions with analysis of facts. "To encourage the use of intuitive perception by professionally young nurses may result in the risk of patients' lives" (Schraeder & Fischer, 1986, p.162).

Conclusion

Intuition as a way of knowing in nursing has been submerged by the reductionist thinking of the biomedical model. Aspects of the literature questioned this, and theories have been developed which have highlighted the importance of intuition as a way of knowing, grounded in experience.

My personal discoveries through exploring these theories in relation to my nursing practice have shown that I use intuition constantly to decipher my multifaceted work, and act upon this information cohesively, integrating empirical knowledge with other ways of knowing.

Beginner nurses need to back up intuitive insights with objective data. Proficient or expert nurses however can use intuition as a valuable nursing tool, equivalent to an artist's eye. This enables them to aesthetically compose, balance and connect the different facets of their caring skills, just as the artist balances the shapes, forms and colours of his/her creation.

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Beginning Journeys - Volume 5

Caring & Growth Life-span Development

A Description Of The Developmental Theories Of Erik Erikson And Jean Piaget. Introducing An Introspective Examination Of A Personal Life Span In "My Story"

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This article begins by describing the processes and periods of life-span development. It then describes the theories of two developmental theorists, Erik Erikson (1968, as cited in Santrock, 1997) and Jean Piaget (1954, as cited in Santrock), before presenting my lifeline in the form of a written story. The purpose of this story, which takes a brief look at my history before projecting into the future, is to link events to the processes of development and incorporate ideas proposed by Erikson and Piaget. In places where they have not appeared relevant I have incorporated ideas from alternative developmental theorists such as Levinson (1978, as cited in Santrock), Perry (1970, as cited in Santrock) and Schaie (1977, as cited in Santrock).

Processes of development

Santrock (1997) describes development as the pattern of movement or change that begins at conception continuing through the individual's life-span. It is a complex process because it is the product of the interplay between biological, cognitive, and socioemotional processes. Biological processes are concerned with the individual's physical changes, cognitive processes with changes in their thinking and socioemotional processes with changes in their relationships and emotions. These processes, through their interplay, influence one another in an inhibitory or progressive way.

Santrock also mentions *maturation* and *experience* as being additional factors that influence development through their interplay. These represent the basis of the *nature-nurture* debate within psychology. The issue centres on whether development is primarily influenced by maturation ("nature") or experience ("nurture"). Those believing in the individual's biological inheritance as the most important influence in their development are "nature" proponents, whereas those who believe their environmental experiences are the most important are the "nurture" proponents.

Periods of development

To assist in our understanding, Santrock (1997) explains that development is organised into distinct periods and he describes the generally accepted structure as a sequence of eight periods: prenatal period (conception to birth), infancy (birth to 18 or 24 months), early childhood (end of infancy to 5 or 6 years), middle to late childhood (6 to 11 years), adolescence (10/12 to 18/22 years), early adulthood (late teens to early thirties), middle adulthood (30/45 to 60's), late adulthood (60's/70's to death).

Developmental theorists

Santrock notes that there are five major theoretical perspectives in life-span development. These are psychoanalytical, cognitive, behavioural/social learning, ethological and ecological, highlighting the complexity of the issue. Whilst maintaining that no single theory, from whatever perspective, has been able to account for all aspects of life-span, he points out that they tend to be complimentary of one another rather than contradictory. A suitable analogy could be that of a "picture puzzle" where the various theories represent the separate pieces which individually contribute to the creation of an overall picture of life span development.

The developmental theorists who I shall examine are Erik Erikson, and Jean Piaget.

Erik Erikson (1902-1994)

Erikson is a developmental theorist who believes that we develop in psychosocial stages, identifying the developmental changes occurring throughout our lifespan. His theory is structured upon eight stages that we all must go through, with each one representing a specific age related developmental task that we must confront. Erikson (1968, as cited in Santrock, 1997) describes each stage as a crisis because the very nature of each stage presents us with the potential for increased vulnerability or enhanced potential. The fundamental point is the more we are able to resolve each crisis successfully the more positive and healthy our development will be.

Erikson's (1968, as cited in Santrock, 1997) eight stages of development are arranged in order of development closely following the generally accepted periods of development referred to previously:

Erikson's stages Developmental period & characteristics

1. *Trust versus mistrust Infancy (first year)* - A sense of trust requires feeling of physical comfort and a minimal fear/apprehension of the future.

2. *Autonomy versus shame and doubt Infancy (second year)* - Discovery of will. Assertion of autonomy/independence. If restrained or punished harshly-sense of shame or doubt may develop.
3. *Initiative versus guilt Early childhood (preschool years, three to five years)* - Assumption of more responsibility. Irresponsibility associated with guilt.
4. *Industry versus inferiority Middle and late childhood (intermediate school years, six years to puberty)* - Mastering of knowledge & intellect. Failure to do so competently associated with feelings of inferiority.
5. *Identity versus confusion Adolescence (ten to twenty years)* - Individuals explore who they are, where they are going.
6. *Intimacy versus isolation Early adulthood (twenties to thirties)* - Forming of intimate relationship(s).
7. *Generativity versus stagnation Middle adulthood (forties to fifties)* - Assisting/helping the development of the next generation.
8. *Integrity versus despair Late adulthood (sixties onwards)* - Retrospection. Looking back at life with satisfaction or dissatisfaction.

   Source: Santrock (1997)

Santrock (1997) describes Erikson as having taken the psychoanalytical perspective in the construction of his theory. Erikson (1968, as cited in Santrock) believes that development is primarily unconscious and strongly influenced by emotion. Piaget (1954, as cited in Santrock) differs from Erikson in that he follows the cognitive perspective, emphasising development through conscious thought as being the prime determinant of behaviour. Piaget also differs from Erikson in that his stage theory contains only four stages of development covering the period from birth to fifteen years of age, or adolescence:

Piaget's stages Age range and description

1. *Sensorimotor Birth to two years* - Infants construct an understanding of their world by coordinating sensory experiences with physical actions.
2. *Preoperational Two to seven years* - Children begin to represent their world in images, words, and drawings.
3. *Concrete operational Seven to eleven years* - Children begin to apply logical reasoning that is applied to concrete as opposed to abstract situations.
4. *Formal operational Eleven to fifteen years of age* - Individuals develop abstract thinking.

   Source: Santrock (1997)

Therefore, whilst Erikson and Piaget take different theoretical perspectives they share a similarity in that they are "stage theorists", emphasising the view that development involves distinct stages in the lifespan that are qualitatively different from each other -*discontinuity of development*.

Discontinuous, qualitative development is described by Santrock as being, for example, when a child moves from not being able to think abstractly about their world to being able to. He also explains that both Erikson and Piaget emphasise *continuity of development*, which is the view that development is a continual, cumulative process. He describes this concept using the example of puberty. It appears to be a sudden event that comes and then is gone. Therefore it could be interpreted as a discontinuous stage of development. The reality is that it is a gradual process that occurs over a relatively long period of time.

The distinction between the two theorists acknowledgment of continuous development appears to be related to the extent to which it is emphasised. Erikson's (1968, as cited in Santrock, 1997) psychoanalytical perspective would appear to place a greater emphasis upon a parallel relationship that covers lifespan development from infancy through to late adulthood and death, than Piaget's (1954, as cited in Santrock) cognitive perspective which, whilst acknowledging discontinuity and continuity of development stops at late childhood. The reason is that Piaget believes that an adolescent and an adult both think in the same way; you are as "smart" as you are going to be by the time you reach adolescence.

"My Story"

I was born in a small village in the Southern Uplands of Scotland, and thus became a member of a continuous community that is able to trace its origins back to the time of the Roman Emperor Antoninus. Anthropological study of the area supports the belief that it is the site of one of the northern most Roman forts that were established at the time that the Antonine Wall was constructed by Antoninus in order to contain the "Barbarians" in the north. This community was the "seed" for many of the present day descendants.

At the time of my birth the village was a happening place in terms of the size of the population and the level of economic activity. The modern day function of the village was centred on the railway junction that had

been developed to deal with the flow of rail traffic between England and Scotland. The Junction symbolised the vitality of the "hot technology" of the 1960s economy. The manufacture of engineering equipment and machinery of many descriptions was the basis of the economy and the social structure in this part of the country. Add to this the sexual revolution, the Beatles and the challenge to the conservative values passed over from the 1950s, it was a heady time. I can even remember singing along to the Beatles tune "Yellow Submarine" when it first came out on the radio.

My first conscious memory, however, was not of the Beatles but of laying down in my cot. Strangely this is also associated with an overpowering sense of falling through a dark void. It seems ridiculous to mention and I do so with some hesitancy because it defies any conventional explanation or understanding. However, the experience has remained in my conscious mind to this day.

Significant memories in my past are few in number and interest. In my early childhood I recall the achievement of tying my own shoelaces. It stands out as being significant presumably because at the time it represented to me the successful accomplishment of a complicated task. In that sense I believe that it reflects an aspect of cognitive development proposed by Piaget (1954, as cited in Santrock, 1997): the *information processing approach*, described by Santrock as being concerned with how information enters our minds, is stored, transformed and retrieved to perform complex tasks. I must say that I was quite pleased with myself, although I cannot remember if I successfully undid them afterwards.

In early childhood I also recall experiences that illustrate Erikson's (1968, as cited in Santrock, 1997) view concerning *autonomy versus shame and doubt* that illustrate an aspect of my socioemotional development. My father was a strict disciplinarian. It was a behavioural characteristic that was perhaps reinforced by his military background. However, in my experience this is an issue that could not be neatly confined to a particular period of development; that the "crisis" occurs at a given point and is then not revisited. My experience would suggest that the "crisis" and the "resolution" exist on a continuum. This is to say that they do not necessarily occur at a set point in a predetermined sequence never to reappear. For me this stage existed into early adulthood and it represented a battle where the lines of advance and retreat were in a constant state of flux. I feel this was attributable to the "Calvinistic" nature of my father's parenting. No doubt he felt that he was doing the best and had adopted this method of child-rearing from his own father who was an equally strict disciplinarian. Oh heavenly days.

Beginning school was naturally a significant event. Entering a very different social environment to that which I had known to this point. Meeting new people, teachers and other school children, who were "outsiders" to my own extended social group, and experiencing new and different ideas and ways of behaving. I clearly remember befriending a Gypsy boy and going to his "home", a caravan in a farmyard, for the first time. His mother was very distant and cool. She didn't act in a hostile way, but neither did she make any attempt to encourage my friendship. Initially I felt bewildered. It was only later, when I became aware of the bigotry surrounding Gypsies, that I understood. In her way she was protecting her child. It made me feel very sad that I should have been prejudged but, of course, I could understand. I often wondered what became of him after he and his family left the area.

Erikson's (1968, as cited in Santrock, 1997) developmental stage *initiative versus guilt* seems to relate to my perception of what was happening in terms of socioemotional development: the exposure to a wider social world, facing the challenge of developing a sense of responsibility through forming behavioural responses to deal with those challenges inherent in adapting to new relationships and a new "learning" culture.

In terms of physical development, another memorable event was the transition from childhood to adolescence with the arrival of puberty-the creation of man from boy. For me it was a period of frustration rather than one of being liberated to chase the opposite sex. The frustration came from the feeling that I did not want to go through all that "hassle". I wanted life to be a "video-tape" so that I could fast forward past it.

Most of my knowledge about what was happening in terms of physical development during puberty came from surreptitiously reading medical books in the public library. In fact I had done the research before puberty hit me fully in the face, becoming so knowledgeable that I was literally holding secretive counselling sessions with other boys, the "early developers", to explain to them the "birds and the bees" with the "extras". However, I have a sneaking suspicion that in some cases the information was used in ways that I had not intended.

On reflection I feel that my frustration was aggravated by the fact that I was a "late developer". I knew what was coming, and I watched most of my peers go through the change while still waiting for it to happen to me. I think this in itself had a subtle impact in terms of individual and group identity. In regard to the latter I no longer felt that I was a complete member.

Entering early adulthood as a single person could be described as a milestone of a sort. Whilst I have remained single I have developed intimate relationships with people of both sexes, maintaining my independence and sense of identity. According to Erikson's (1968, as cited in Santrock, 1997) theory this stage is represented by the *intimacy versus isolation* crisis, which I feel does describe my socioemotional development at this time.

My cognitive development in early adulthood appears to reflect the ideas proposed by the developmental theorist William Perry (1970, a cited in Santrock, 1997) as opposed to Erikson or Piaget (1954, as cited in

Santrock). For example, unlike Piaget, Santrock explains that Perry believes that adults do think differently from adolescents. In adulthood the individual's thinking matures in response to becoming aware of the diversity of opinion and multiple perspectives held by others. As a consequence they develop their thinking with the potential to progress through different levels to the point of *full relativism*: the point at which the individual comprehends that truth is relative and that truth is not absolute. I feel that my thinking has developed in a way that is supported by Perry's view, and continues to do so as I now approach middle adulthood.

Looking towards the future of middle adulthood and beyond it occurs to me that I have preceded a feature of middle adulthood development proposed by Daniel Levinson (1978, as cited in Santrock, 1997). Santrock explains it as being a period of development that can involve a mid-life career change. Of course I am now in the process of establishing the foundation for a new career. So it would seem that where I am now perfectly mirrors Levinson's view.

Projecting forward to late adulthood I have a recurring mental image of "Last of the Summer Wine". Which character I will turn out to be is still up in the air, although I do think it would be fun to follow in the footsteps of "Compo". The idea of being able to leave behind all that prim and proper behaviour, discarding all that is politically correct, and getting down to the essence of it all does appeal. At this stage of life it matters less who thinks what than at any other. In this sense I agree with the cognitive developmentalist theorist K. Warner Schaie (1977, as cited in Santrock, 1997) who describes the final stage of development as being *reintegrative.* This is where the individual consciously chooses to focus upon those things that have real and true meaning to them; that what is relevant or appropriate to learn, think about, or do is different to that which would have been so during the earlier stages.

Undoubtedly at this point in my life I will, as Erikson (1968, as cited in Santrock, 1997) suggests in *integrity versus despair*, reflect upon what has been and do so with an overall sense of contentment. I also imagine that despite not having had children of my own I will have successfully resolved the penultimate stage- *generativity versus stagnation* through my nieces and nephews.

The issue of spiritual development is one that I have deliberately left to the end of my "story", as I find it difficult to fit my experience within the context of a particular theorist. Santrock (1997) puts forward various theoretical frameworks for understanding religious development, yet whilst I attended the traditional Sunday school his descriptions of what should be happening does not match with what was going on in my head. From a very early stage I determined in my own mind that the traditional or conventional image of spirituality did not ring true. Perhaps this was because of my exposure to a relatively wide range of "belief systems" from an early age, such as Celtic and Gypsy folklore. The consequence of this is my personal belief that we are part of a collective consciousness whilst existing in this present dimension as apparent separate entities. Within this context the concepts of "Good" and "Evil", "God" and the "Devil", are simply constituent elements that are part of us all, whether in this or another dimension.

Life span development as with any other science, such as physics or biology, is represented by a diverse range of theories encompassing different theoretical perspectives. This implies that no single theory or theorist has the complete or correct explanation of life span development. For example, at the beginning of this article I have described the theories of two major developmental theorists, Erikson and Piaget, representing the pychoanalytical and cognitive perspectives respectively. I have also related the additional theories of Levinson, Perry and Schaie to my own life span development in "My Story".

I believe that "My Story" illustrates the apparent complexity of life span development by its resemblance to a "picture puzzle", with the pieces of the puzzle being represented by different theories which although sometimes disagreeing tend to be complementary rather than contradictory. Therefore, it would seem that the "Story" of each individual will resemble an amalgam of different theories creating a picture of their own life span development as unique as themselves, with the distinct possibility of discovering that it does not neatly fit one particular theory but a "quilted patch work" of existing theoretical frameworks.

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Beginning Journeys - Volume 5

Stress & Burnout: A Nursing Perspective

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Stress commonly affects individuals in the nursing profession, sometimes in the extreme form of burnout. This topical issue will be explored in terms of the effect burnout has on New Zealand's health status and the relevance of burnout to nursing practice.

Burnout is pervasive in the working lives of people today and is especially prominent for those in the 'helping professions' (Mulligan, 1998). Insight into the nature of this important health issue is necessary to determine its appropriate management. Steps for positive management of burnout within the ranks of nursing are discussed. Means of supporting the management of burnout at local, national and international levels are also outlined.

The experience of 'stress' is a combination of physical and psychological components. The stress response is not necessarily harmful. Stress can be positive and rewarding, such as when an individual pushes their personal capacities and resources to meet a challenge or goal. Negative stress, or 'distress', occurs when there is overload of physical and/or mental stress on the body. This may be due to chronic pressure, tension and fatigue, which lowers resistance and limits the person's adaptive capacities (McConnell, 1982).

For the purposes of this discussion the words 'stress' and 'distress' will be used interchangeably. Stress is the individual's response to a perceived situation, event, or circumstance that appears to be beyond their control. In its more severe form stress may become 'burnout'. Maslach and Jackson (1981, cited in Mulligan, 1998, p.1) describe burnout as "a three dimensional syndrome characterised by emotional exhaustion, depersonalisation (negative, cynical attitudes and feelings towards recipients of one's services) and reduced personal accomplishment (the tendency to evaluate one's self and one's work negatively)."

Mulligan (1998) goes on to identify symptoms of burnout and costs to both individuals and organisations. Individuals may experience physical, emotional and mental exhaustion. This exhaustion may be characterised by chronic fatigue, feelings of helplessness and entrapment, and negative feelings toward oneself and work or life in general. Psychological ailments suffered may include ulcers, migraine and chronic backache. Excessive sick leave and substance abuse are also symptomatic of burnout.

At an organisational level the symptoms of burnout are both numerous and crippling. These include poor performance of personnel, loss of skill base through resignations, wasted training and resources, and recipients of services receiving poor services.

The cost of burnout to individuals and organisations has a direct impact on New Zealander's health status and health services (Mulligan, 1998). People with chronic physical and emotional exhaustion are more susceptible to infection and disease. Those individuals experiencing intense feelings of inadequacy and incompetence are more likely than others to suffer depression. Psychosomatic ailments such as ulcers and backache further debilitate the population. Furthermore, those who incur job loss due to burnout are more susceptible to physical and emotional problems as a result of coping with unemployment and limited resources.

Burnout can therefore compromise the health status of New Zealanders. This in turn may lead to increased pressure on health professionals for their services. Those professionals in direct, continuous contact with people are more likely to suffer the effects of stress and burnout; this is especially true of the nursing profession (McConnell, 1982).

Bailey, Burnard and Smith (1987, p.17) define burnout as "an evolutionary insidious process of growing emotional exhaustion, occurring in a nurse as a consequence of being exposed to chronic work-related stress." These authors discuss depth of commitment and intense personal and professional involvement as key factors in the cause of burnout. This is particularly so for psychiatric, oncology and intensive care nurses. However, all nurses are exposed to burnout risks due to the nature of their work.

Four major stressors that are confronted by health professionals and that contribute to burnout are described by Mulligan (1998). The first is *client contact*; both hours of direct contact with clients and severity of client's problems. The second stressor is *role conflict/organisational context*. Leiter (1992, cited in Mulligan) found that bureaucratic organisational structure inhibits initiative and individual responsibility. Health professionals who use a range of positive stress coping strategies in their work may however experience stress between the requirements of their work role and management practices. This comes about as the self-management strategies individuals use to cope may not be aligned with approved management practices. For example, at mealtimes a nurse may give minimal assistance to clients who have been assessed as able to feed themselves. Instead the nurse concentrates on the clients requiring some help with eating. However, management policy may require that nursing staff supervise clients individually at mealtimes, thus 'stretching' nurses resources and increasing tasks and stress levels in an already busy day. In the organisational context uncertainty over changing work roles and workload also need to be considered

as factors supporting burnout.

The third stressor that may affect health professionals is *lack of support*. This includes limited support from colleagues, senior staff and counsellors. Limited continuing education and resources (to improve communication and stress management skills) may also impact. *Personality and social factors* are also stressors that may contribute to burnout. For instance lack of problem solving skills, high personal performance expectations, a tendency to lose professional objectivity and poor personal relationships may all contribute.

For the nursing profession the effects of burnout can be devastating. Mulligan (1998) identifies staff leaving the profession, or remaining in the profession but operating at a level that is unsatisfactory. This may result in higher levels of absenteeism and a drop in performance standards.

Burnout may also be more insidious in nature. McConnell (1982) describes horizontal violence as personal conflict transferred to others, thus becoming interpersonal conflict. For example, a nurse who is frustrated due to increased workload may refer to a junior staff member as irresponsible and treat them as if this were true. Substance abuse is another insidious effect of burnout. As stated by New Zealand Nurses Organisation (1987) alcohol and drug abuse is a health problem that affects nurses at all levels. It affects standards of care and the safety of clients; it costs nurses their jobs, families and sometimes their lives.

Burnout is a compounding problem for nursing professionals. Nursing staff who are able to cope with the pressures of their work are subjected to increased stress when covering for their 'burned-out' colleagues. In addition there may be conflict between the two groups, adding to the stress cycle for all involved.

It is therefore crucial that the nursing profession confront the problem of burnout by dealing with the core issues. McConnell (1982) identifies three coping strategies nursing professionals should consider when addressing burnout: *self-management*, *organisational improvement* and *use of support systems*. *Self-management* hinges on awareness of stressors and the effects of stress. Nurses then develop positive coping strategies for each problem. Self-management strategies may include learning new knowledge and skills, or setting clear, attainable goals. Nurses should remember to support the basic habits of good health: adequate nutrition and regular physical exercise.

Organisational improvement relates to changing the staff policies and procedures of a health organisation to decrease the incidence of stress and burnout. For example, reducing staff-client ratios allows for staff to focus more on the positive aspects of their work. The resultant satisfaction for the nurse will decrease the risk of burnout. Health organisations need to consider the cost-benefit equations of staff burnout regarding waitlist pressures (Mulligan, 1998). Another organisational improvement is limiting hours of stressful work. Maslach and Pines (1988, cited in Mulligan) found longer direct contact hours with clients increased stress and burnout. Consideration could be given to creating part-time positions, having shorter work shifts and the use of task rotation to provide a balanced workload. In short, health organisations must ensure flexibility in their work environments if staff burnout is to be reduced.

Support systems are crucial for preventing burnout (Mulligan, 1998). This may involve simple colleague support such as spending a moment to praise, discuss, or simply acknowledge personal needs. On a more formal level, productive support sessions involve sharing feelings and participation in the establishment of unit goals and objectives. Taking action under stressful conditions (rather than remaining passive) is a powerful coping strategy. Support systems such as training (improving communication, learning skills for giving and receiving support, burnout workshops and appropriate supervision) and education (providing realistic job descriptions and stress management skills) are methods of taking positive action.

To prevent the occurrence of burnout nurses must support good work practices on a local, national and international level. Locally, nursing staff can join formal and informal support groups to discuss personal and professional issues. As a nursing group, health agency management can be lobbied to support increased flexibility with client management, decreased staff-client ratios and the provision of stress management workshops. Membership of the New Zealand Nurses Organisation will inform nurses of health issues that may impact on their working environment. Moreover, by supporting the provision of workplace employee assistance programmes, nursing staff can help combat one of the results of burnout, substance abuse (New Zealand Nurses Organisation, 1987). Those in the nursing profession must also be proactive in educating other health professionals and the public about the nature and impact of stress and burnout.

Nurses at a national level can act to limit burnout by networking between their local groups. Exchange of ideas and strategies for the prevention and management of burnout are valuable. Through lobbying for support from the New Zealand Nurses Organisation, other union bodies, and employers, nursing groups could set up national workshops on burnout that benefit those in the helping professions and the public.

Internationally, the New Zealand Nurses Organisation, along with other nursing bodies, can continue active involvement with the International Council of Nurses (I.C.N.). As an international and political power I.C.N. is able to influence health and nursing policy world wide and could do much to educate the helping professions on the issue of burnout.

Conclusion

Stress has been identified as a pervasive influence in New Zealand society. No one is immune to its effects, and this is especially the case for health professionals. Burnout is a public health issue that nurses must

cope with personally and professionally. Ironically an increased demand for nursing services will result in a higher rate of burnout among nursing professionals.

The impact of burnout in the nursing profession should not be taken lightly. Burnout may lead to high staff turnover, poor standards of care, horizontal violence, and substance abuse. There are a number of effective strategies for nurses to combat burnout; these include self-management, organisational improvement and use of support systems. However, in order to maximise the benefit of these strategies, nurses should support them on a local, national, and international level. Therefore to counter burnout, actions as simple as one colleague supporting another in a difficult situation, through to organising and attending a national workshop, are vital. As health professionals, nurses have an obligation to educate their students, other health professionals, and the public on the issue of burnout.

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Beginning Journeys - Volume 5

Exploring the Construction of My Cultural Identities

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Introduction

In this article I will give definitions of culture and show how, through the process of socialisation, my cultural identities have evolved. I believe the process of cultural identity development is a continual process and I will describe situations where my cultural identity has been altered by my life experience.

I will identify and discuss three of my cultural identities; ethnic identity, special needs parent and student nurse. In so doing I will evaluate how these may influence my personal awareness of my nursing practice.

Examples of reflection on practice will be given through the inclusion of exemplars. My personal goals to practising cultural safety effectively in my nursing practice will be outlined.

Defining Culture

Culture can be defined as "knowledge, beliefs, values, customs, habits and behaviour shared by people within a particular society" (Cockerham, 1995, p.66). Cultures evolve as a way of living developed historically and passed on generationally. Santrock (1997, p.15) defines culture as "the behaviour patterns, belief, and all other products of a particular group of people that are passed on from generation to generation". The components of culture are values, norms, language and rules for behaviour that prescribe what is good and proper, right and desirable (Spector, 1991, as cited in Potter & Perry, 1997). An individual's cultural background may determine his or her beliefs, actions and thoughts.

Cultural/Ethnic Identity

Thinking about my own cultural identities and how they affect my nursing practice seems a bit premature. I had to ask myself the question 'what aspects of my cultural identity draw me to a vocation in nursing?' These form some of the belief systems and structures I operate from.

It was a question that provoked a contemplation of my ethnic identity and also the roles I have played in the culture of the society I live in.

Ethnicity is explained by Santrock (1997, p.15) as being based on "cultural heritage, nationality characteristics, race, religion and language", and he argues that ethnicity is pivotal to the evolution of ethnic identity. Santrock (p.15) also defines ethnic identity as "a sense of membership based on the shared language, religion, customs, values, history and race of an ethnic group".

My ethnic identity is that of a white New Zealander. It is where I feel I belong even though I do not share all the above mentioned characteristics with my fellow country people. I am of European descent and my language is English. My language is the same in the English dictionary. However, in daily life there are pronunciations and colloquialisms not comprehended by people with English as a second language, such as, 'bloody oath', 'slow as a wet week', 'she'll be right'. New Zealand language is also comprised of smattering's of Maori, Scottish, French and German words to name a few. As an immigrant culture we incorporate to assimilate. My Kiwi culture incorporates traditions, customs and values of the British Isles. These have been selectively kept and altered by the Pacific influences of the indigenous peoples and the environment.

My cultural identity, learned in my primary groups, was as a New Zealand girl of English descent. My family group is predominantly my mother's matriarchal line who have lived in New Zealand since the 1850s. There are traditions of home making and colonial ingenuity that pervaded my role modelling through generational learning. The mothering, caring and nursing roles are traditional in my female working class ancestry. Within my generation of our family line are the first female tertiary graduates. So far, it is only the female children who have broken with traditional roles, the men have opted for trade qualifications.

I was born when my parents were in their mid-twenties . This was at the tail end of the 1960s and the global movement was for change. Industry and technology were fast changing social structures. My first peer group and school environment was in a seaside suburb of Christchurch. My class mates were predominantly white and from middle to lower class backgrounds.

When I was eleven we moved to the country and into an agricultural community. This was a society where the rules that had applied to my colonial ancestors still strongly influenced the present day . Here began a secondary socialisation phase in my life. Secondary socialisation is defined by Cockerham (1995, p.81) as 'any process that inducts an already socialised individual into a new role or position in society'. I had a new role and position as a member of a farming community. My peer group changed slightly but the predominant cultural influences were still anglo-saxon. The family group structure was almost exclusively the married two parent structure. Fathers worked the farmland and mothers ran the households. Gender roles were strongly defined. In times when intensive labour was required everybody dug in, including the children.

As the eldest child, one of my roles in the family group was to oversee my younger siblings. This instilled in me a sense of responsibility, organisation and an awareness of those outside the self. My caring role was beginning to form as a cultural identity. At the divorce of my parents, my role extended to being the deputy parent. Now household planning was required. There was also an increased awareness of age related ability and intuition of my siblings needs. On reflection, many parts of my socialisation have prepared and equipped me with the skills I perceive are required in nursing.

Community consciousness and collective good is the basis of the rural value system. This was a very different structure to the city community structure. In the city we relied on shops and mass production of consumer goods. On moving to the country my family began to discover self sufficiency and self reliance. We cultivated our own vegetables, fruit and herbs. We reared and butchered our own animals, milked the cow and made our own dairy products. We produced all our own baked goods, buying only staples of grains, pulses and essential processed goods from shops. We often shared the bounty with neighbours. There was a sense that as long as you contributed to your own survival and that of the rural community, your ethnic background was of little consequence.

Historically there is a family practice of Anglican and Methodist Christianity. Neither my parents nor grandparents attend church services, however the values and moral guidelines of the Christian faith remain strongly ingrained. This is not to say we have a belief in creation. Spirituality is something my mother has explored throughout her life. This openness to learning something so deep at the core of many cultures has enabled our family to attend a variety of sacred ceremonies. These include Krishna, Buddhist, Christian, Maori and Pagan rituals.

Bell (1996) questions the reality of our national image. Bell infers that the typical Kiwi character is a construct of a media machine fuelled by politics to incite nationalism. While I consider that we are becoming a culture defined by the mass media I think the Kiwi bloke is still a very real character in New Zealand culture, perhaps a minority as Bell argues, but real all the same. My belief stems from my experience of rural New Zealand culture in which I met these people and identify with the culture they represent.

My identities within this culture are both static and changing. I feel that while I was born into the English ethnic group, my ethnic identity incorporates characteristics and values of other ethnic groups. My changing cultural identities relate to my relationship, parental, employment and economic status within cultural social constructs, as well as my changing environment. My goal is to continue to be open to identifying situations that illuminate cultural influence in my nursing practice.

Identity as parent of a special needs child

For the last seven years one of my predominant cultural identities has been that of a parent of a special needs child. The subculture of parenting is dynamic and profound. Parenting a special needs child adds a whole new dimensions to the induction into the subculture of parenthood. At the birth of my son I became immersed in a subculture more profound and consuming than those that had involved me previously. As a mother of a child with a chronic health problem I played a variety of roles including parent, student, educator, advocate, health care purchaser, private voluntary provider, therapist. This was a huge learning curve as a first time mother in her early twenties.

At the beginning I felt medical professionals were the people to prescribe the appropriate level of care and investigation into my sons condition. My socialisation dictated that doctors and nurses where more learned and wise. In dealing with medical specialists, usually European men in their mid-fifties, this way of relating was re-enforced. They expected a parent to comply and not to question their diagnosis.

There was also the fact that I was a stranger in this culture of medicine. I could not understand the language. I did not know the routines or have any conception of the practice rationales. I have lived the culture shock which comes with the acute onset of a life threatening situation. I held the firm belief that my son needed medical intervention to better his life. This forced me to learn the culture of medicine.

Within two years of this resolve, my son was diagnosed with severely decreased hormone production due to dysplasic hypothalamus and pituitary glands. I learned to talk the doctor's language and continually prove my comprehension, in order to hopefully gain their partnership. As I learned things I had to be able to translate the information to family and friends. To say 'Septo-optic dysplasia causing panhypopituitism, diabetes insipidus and hypoglycaemia' to your average man on the street is 'martian' as far as they are concerned. I had the drive to sift through medical dictionaries and text so that all involved with my son's care had the facts in language they could understand.

There was a mixed response from medical staff on my quest for knowledge and new found assertiveness. Some thought I was questioning their ability and encroaching on their domain. Others were supportive and helped to teach me to provide optimal care and advocacy for my son. Others did not care what I knew, wanted to know or assumed to know, as long as I didn't bother them or get in the way.

This is only one side my experience of hospital culture. The other was of a caring environment that promoted health and I journalled about this on 28.4.99.

I hope I can remember to be present with the people who come into my practice. There is no denying that time is scarce and individual responsibility and work load are often at maximum. I just know when J. was in the ward or in Accident and Emergency, it was those people who offered normalcy in one to one relating

who saved my sanity and buoyed my spirit.

Being treated like a number, a disease, a disability or a nuisance is demoralising, demeaning and detrimental to health.

I bring this to my nursing practice. It is my intention to hold my experiences up as measures for interpersonal relationships in clinical practice. I hope to approach all clients with an open mind and to not make judgements on how they should adapt to society.

Student identity

Presently the undertaking of further education finds me facing new beginnings in the student culture. There are feelings of both challenge and uncertainty as I enter into another sub culture. Short, Sharmen and Speedy (1993) examine nurses 'occupational socialisation'. Short et al. state that by choosing 'nursing as a career (the student) will be required to give up existing stereotypes regarding nursing and adopt those held by members of the nursing profession during professional socialisation' (p.15).

When attending classes there are huge amounts of information about the rules, systems and theories of practice presented. At this beginning level of comprehension the student nurse is in 'the anticipatory phase of socialisation' (Merton, 1968, as cited in Short et al., 1993). We are trying to find role models to emulate in practice and attempting to adopt the values we believe are held by professional nurses. Within the culture of being a student I am at the novice stage where I am learning a new way to interact with my social group. Socialisation as a student seems to evolve from the common ground of attending the institution and attempting to assimilate information gathered. In a journal entry (28.4.99) I explored my learning curve.

I perceive a meshing of theories in my learning. The Benner, from novice to expert idea sets out a rough map of the journey from beginner, where I was nine months ago, to expert nurse (how long does it take?). Anyway, in the last nine months it's been 'sponge brain' time. Learn and spit out is survival at first. As I have got used to the 'new order' of student life I have felt more able to look at/ contemplate what is being built as my practice.

The cultural background of students can vary vastly. Students do have to open their minds to cultural diversity from the very start of their course of study. It is a goal of mine to be open to all experience that positively challenge my cultural belief systems. I hope that my cultural awareness develops personally and also as an integral part of my nursing practice.

Conclusion

In conclusion, I feel that I am now much more aware of my ethnic identity and how that is the basis from which I act in my nursing practice. My primary socialisation set foundations for entry into a caring profession. The experience of parenting a special needs child, challenged and altered my cultural belief systems. From this experience I carry a point of reference for measuring my clinical practice. As a beginner nurse I now more fully understand nursing beliefs and values. It is my goal to incorporate these into my own nursing practice and to maintain a high level of awareness of my cultural practice with colleagues and clients .

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Beginning Journeys - Volume 5

Student Nurses' Attitudes Towards Death & Dying: A Literature Review

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The reality of death and dying is something that we all must face. This article will explore student nurses' attitudes towards death and dying, by reviewing four research articles. First there will be a brief background outlining why research on this topic has been undertaken. Three themes that emerged from the four articles (Beck, 1997; Kao & Lusk, 1997; Loftus, 1998; Servaty, Kerjci & Hayslip, 1996) will be individually discussed. The themes are, death and dying education, communicating with dying patients and previous experience with death and dying and students' attitudes. The limitations of the research studies will be discussed, and finally the need for further research, especially in New Zealand, will be addressed.

Background

As more people are now dying in an institutional setting, they are depending on health care workers to carry out their care and comfort. Nurses are the health professionals who carry out the majority of their care. This is an emotionally demanding area for nurses. Student nurses are also very much involved in the care of dying patients. Much overseas research on the relationship between death and dying of patients and student nurses has been carried out since the 1960s (Beck, 1997; Kao & Lusk, 1997; Loftus, 1998; Servaty et al., 1996). This research has focused on the influence of death education for nursing students, nursing student's attitudes towards caring for dying patients, and how student nurses cultural influences affect their attitudes towards death and dying (Beck; Kao & Lusk; Servaty et al.)

Literature Review: Death & Dying Education

Caring for dying patients can be a frightening experience for student nurses. Throughout the articles the research has suggested that student nurses may not be receiving adequate education to prepare them to care for dying patients (Beck, 1997; Kao & Lusk, 1997; Loftus, 1998; Servaty et al., 1996).

Why are student nurses not receiving adequate education in caring for dying patients? Beck (1997), Loftus (1998) and Kao and Lusk (1997) suggest an underlying theme of students feeling that their practical skills were not adequate. Beck's qualitative research was a phenomenological study which comprised of 26 student nurses from a university in the United States. Beck found that student nurses anxiety was stemmed from their feelings of personal inadequacy manifesting in a lack of confidence and feelings of helplessness. This is different to previous ideas in death education in which students' anxiety was thought to be caused by concern about their own mortality. To help overcome these problems, Beck suggests that nurse educators should prepare strategies to enable students to develop the necessary skills to care for the dying, thereby empowering students. Kao and Lusk found that the students ethnicity can affect their educational experience. Kao and Lusk's research was a quantitative study using a comparative, descriptive design. The participants were seventeen Asian and eleven American graduate student nurses from three universities in the United States. It was discovered that Asian students had less hours of death and dying education. Their mean was *1.4 hours, compared* to American students mean of *= 5.5 hours*. Their explanation was that Asian culture does not allow nurses to discuss death. However, due to the lack of death education, Asian students were noticeably more anxious about death.

Communicating with Dying Patients

Communicating with dying patients can be a difficult experience for student nurses. Beck (1997) and Kao and Lusk (1997) both agreed that the most difficult aspect of communicating with a dying patient for the students was talking about death and dying with the patient and their family. Kao and Lusk discovered Asian students found communicating more difficult than the American students and though they performed their nursing skills, the Asians were less likely to interact with dying patients.

Servaty et al. (1996) undertook research from a quantitative perspective related to students communicating with people who are dying. The 129 participants were from a college in the United States and consisted of student nurses, medical students and a control group who thought that nurses were less anxious when talking to dying patients than medical students. Another finding was that first year student nurses were more apprehensive than third year student nurses when communicating with dying patients. This suggests that education, life experiences, age and maturity could influence students communication skills. Beck (1997) found that students also discovered that being present in a patient's room and using touch were effective ways of communicating. In comparison to the other three articles (Beck; Kao & Lusk, 1997; Servaty et al., 1996), Loftus (1998) did not mention any obvious issues of communication apprehension in her research. This research was a qualitative study, using a phenomenological approach. The method used was informal interviews with five participants.

Previous Experience with Death and Dying and Students' Attitudes

The research (Beck, 1997; Kao & Lusk, 1997; Loftus, 1998; Servaty et al., 1996) has shown that the

majority of students with previous experience in dealing with death and dying, either in an educational or personal setting, were more at ease in caring for dying patients. This also depends on the student's first experience with death. For example, in most western cultures (and perhaps Asian) children are sheltered from the realities of death and dying. Most people believe that hospitals are where people get better rather than die. This concept, that people do actually die in hospital, can be a harsh reality for student nurses. All of the students in the research had had previous experience in caring for dying patients (Beck; Kao & Lusk; Loftus; Servaty et al.)

Limitations of the Research

Beck's (1997) phenomenological research involved students writing down descriptions of their experiences. This may not have been an effective way of expressing thoughts and feelings for all the students. The participants came from the same university, and so, the research may not be generalizable to student nurses elsewhere. The gender balance is ambiguous, but this is due to anonymity issues.

The sample size of only twenty eight in Kao and Lusk's (1997) research was very small in terms of quantitative research. There was no mention of the gender balance in the sample. This leaves the impression that only females participated in this research. The use of the questionnaire could have limited the participants' responses.

Loftus (1998) did not state where her research was undertaken, but, with the mention of Scottish terms, it is presumed that it was Scotland or England. One of the six participants was male. This again was not stated, but was discovered in the literature. Consensual validation was not obtained in response to the interpretations. The literature mentioned that six themes emerged, but only focused on three, and there was no mention of the remaining three themes.

The participants from Servaty et al.'s, (1996) research was also from the same college. Once again, this may not be generalizable to other student nurses. The results section was extremely difficult to follow.

There is a need for further research in relation to this topic, especially in New Zealand. While researching this topic, one New Zealand article was found (Charlton, Ford & Manderson, 1995). As it was a review of research undertaken in 1992, it was therefore not relevant for this assignment.

Many questions need to be answered by further research and include the following: how do male nursing students cope with caring for dying patients? Are New Zealand student nurses getting the support and education that their overseas counterparts are obviously lacking? How does New Zealand student nurses cultural identities and ethnic background effect their care of dying patients? Finally, do New Zealand student nurses' attitudes towards death and dying differ compared to the findings in this review?

Conclusion

The review of four research articles has shown that student nurses' are not receiving adequate education and support to help them care for dying patients. Also, the students cultural background plays a huge part in their attitudes towards death and dying. The research has highlighted that communicating with dying patients and their families about their imminent death is the most difficult aspect of caring for dying patients. The limitations of each of the studies have been addressed, and for most of the articles the studies were not generalizable to student nurses elsewhere. Also, most studies had very few male participants. Finally, the need for further research, especially in New Zealand, has been identified. There are many questions that could be answered by continuing research in this area

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Clinical Practice / Education Exchange (CPEE)

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Introduction

In 1998 we (Esther Vallance and Robyn Brasell) embarked on a clinical practice/education exchange (CPEE). This nursing narrative reflects the unique experiences we were involved in. It includes how it came about, what it meant for us, what happened and the results.

How we came to do the exchange

Robyn Brasell

For the five years prior to the exchange I had worked as a nursing tutor at the Christchurch Polytechnic School of Nursing in the areas of Obstetric and Medical nursing. Latterly my focus was in medical nursing in the Long Term Health Alteration paper of the Bachelor of Nursing programme with second year nursing students. After five years my enthusiasm and sense of relatedness to my teaching was severely waning. I felt I needed to narrow the theory-practice gap in the classroom. I had many ideas and time passed as I deliberated. Finally, one idea was fuelled by reading an account of two women in Nelson who had negotiated successfully a CPEE I felt like a journey had begun.

I talked with colleagues at the Polytechnic and at Christchurch Hospital. I finally connected with Esther, a colleague in full time nursing practice. She was very enthusiastic about teaching and students. She was keen to share in an exchange. We talked and talked. We tentatively made enquiries and proceeded together. All this happened at the beginning of 1997.

Esther Vallance

Prior to the exchange I had been working as a part time tutor with students in the first year of the Bachelor of Nursing programme. This involved being with nursing students in clinical practice one day per week. The other four days of the week I worked in an acute medical ward at Christchurch Hospital as a staff nurse. The weeks that I did not have students, for example, in the school holidays, I would work five days a week on the ward. Concurrent to this I was studying extramurally towards my nursing degree as I knew I would need this qualification if tutoring was to be more than on a temporary/casual basis.

I met Robyn when she became the new nursing tutor in the ward at the hospital. Part of my 'brief' as a staff nurse was to buddy nursing students, a role I found challenging and rewarding. It was during this time that I heard Robyn was interested in a clinical/education exchange. I made contact with Robyn and expressed my interest.

What it meant for us

Robyn Brasell

I remember feeling very excited and VERY apprehensive. My thoughts raced ahead and then back. How would the team I taught with accept the idea? How would it all be set up? How much would I be paid? Could I still manage to pay my mortgage? In practical terms Esther and I brainstormed a list of considerations and tasks. Formal correspondence began between the Head of the School of Nursing, Christchurch Polytechnic and the Director of Nursing at Canterbury Health and finally after discussion re terms of the contract the exchange was confirmed on paper! I would take leave without pay from Christchurch Polytechnic and commence a short-term contract with Canterbury Health.

Like starting a new position I needed to find out the requirements for starting work on ward 29 at Christchurch Hospital. This included orientation, intravenous certification, uniforms and linking with the staff I would be working with. I also needed to hand over to Esther the parts of my job which would now be hers. This process took time, we negotiated and by trial and error found our way through.

Esther Vallance

Thinking back I suppose it was nearing the end of the first semester of 1997. I was still studying towards my nursing degree and had quite a heavy workload. I had undertaken to do two Massey papers during that semester as well as clinical tutoring and nursing. I was really keen to get my degree finished by the end of 1997. When I spoke with the Patient Care Manager (PCM) who would be the one to authorise the exchange, she expressed reluctance to release me just as winter was approaching. However she supported the idea of the exchange and suggested that we aimed for the first semester of 1998. In some ways it was a relief to have to wait another seven months. I could finish my degree, have a bit of a holiday and be ready for the new challenge, teaching at polytechnic.

For me, the 'nuts and bolts' were negotiating a contract with polytechnic which would reflect what I was earning as a staff nurse (including shift allowances) and gaining approval for 'leave without pay'. I had never negotiated my own pay rate before so this was a new experience. I worked out in my own mind what pay I wanted and this was granted. Phew! I was relieved about that. The PCM organised the 'leave without pay' for me.

What happened in the Year?

Robyn Brasell

The commencement date, January 1998, for my year of practice as a staff nurse came very quickly. I vividly remember the beginning, a morning duty, a uniform and some apprehension. The Clinical Nurse Specialist and ward staff were amazing, welcoming, accepting and providing me with a wonderful preceptor for a week.

A year of shift work, patient loads and teamwork had begun. Amidst the beginning struggles to keep up and learn, "I absolutely loved it". The staff were unique in what they gave me. Their time, patience, expertise and fun. Lots of fun! The patients taught me so much. The rapid turn over of short patient stays and staffing difficulties etched the reality of nursing in the 90's within me.

During this time I came into contact with Stages 3 and 6 nursing students and what they taught me too was invaluable. Especially the realities of being a buddy to students and being a nursing student in practice. I perceive the value of the staff nurse buddy to be largely unrecognised and undervalued. Finally, I relived the joys and the tears to be found in the richness of nursing.

Esther Vallance

Beginning full time at Polytechnic was the steepest learning curve that I had ever been on. I took on some Certificate in Adult Teaching Courses to assist in my learning of how to 'teach' in a classroom setting. These courses were a real challenge as we had little exercises to do, e.g., preparing a lesson, giving a lesson, reflecting and evaluating our own lessons and lessons that other peers had presented. I had experienced being a tutor in clinical practice but had never learnt 'how' to do it. I spent evenings and weekends learning the content that the students had to know and then rereading and relearning what had come up in class and what I was not sure about. I think the most complex part was the metamorphosis from the type of learner that I was at school and during my own nursing education to the type of learner that was in a nursing degree programme. I had learnt that you rote learn and that the teacher knows everything. Nowadays that is not the case. No one person can know everything and students need to understand that. The focus then becomes not on what you need to know but the skills you develop in finding out what you need to know. How do you access information? How do you work in a team? How do you self evaluate? How do you make links between what you already know to new information? How do you critique information. Wow! A roller coaster ride. When I look back on the exchange I think about all that I have learnt.

The exchange was not just about what I would learn. It was also about what I could bring to polytechnic and the nursing students that I would work alongside. Student's feedback indicated that they really appreciated the experiences of clinical practice that I could share with them as part of the lessons at polytechnic but also when I worked with them on the wards.

The Results (now)

Robyn Brasell

The decision to return to tutoring was motivated by my initial goal to narrow the theory-practice gap and impact my teaching. It was a head decision. I have now returned to tutoring in stage three of the nursing programme with a new focus, a new enthusiasm and a new confidence. The results of the exchange from my perspective have been overwhelmingly beneficial. The exchange for me was a different method of doing research and applying now what I learnt.

I now have a greater awareness not only of the body of knowledge the students need to know but also in the process of learning, the skills they need to develop, ie developing a co-operative approach to learning in the classroom so the students can function co-operatively in the ward or practice situation. Linked with this is the need to develop and grow in their communication skills, to clearly speak, listen, hear and take responsibility so they can be effective and safe in practice.

In my absence Esther brought significant and dynamic ideas to the programme so that today the programme is better. Thank you Esther for your courage. Finally, I am very thankful to the clinicians on the ward, to the Dean of the Faculty of Health and Sciences and the Head of the School of Nursing and to my Stage 3 colleagues for their encouragement and support.

Esther Vallance

What eventuated was that I was offered a year's position in the paper where I had worked part time as a tutor. The hardest thing for me about the exchange was that I had to leave the paper where I had worked for the past year. I really enjoyed the work, the students and teaching initiatives that the team I was in was working on. I also liked tutoring in the ward where I had been a staff nurse. The other difficult decision was whether I would carry on tutoring or go back to the ward. In all honesty I see the issue of 'going back' to be

a real dilemma for those engaging in exchanges. In your mind it's all planned. Six months or a year out and then back again. It is not as easy as all that. It's like replanting a shrub, your roots go down. Regardless of this 'down side' I found the exchange extremely worthwhile and a wonderful initiative in bridging the theory-practice gap. By the way, I stayed in education and the learning curve continues.

To Conclude

Esther Vallance and Robyn Brasell

We both really enjoyed the exchange. We learnt a lot and experienced a lot. We would recommend this exchange approach as a way of identifying key issues relevant in both theory and practice. This concept could be used creatively within the profession of nursing to actively bridge the theory-practice gap.

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Beginning Journeys - Volume 5

PRACTICE IN REFLECTION

Jill Mitchinson - Midwife Practitioner

INTRODUCTION

This article will examine some of the current literature regarding critical social theory and reflective practice. Journaling is an important aspect of reflective practice and the importance of journaling will also be discussed. The personal experiences of the author, when journaling, will be documented in relation to the authors area of practice (a small maternity unit).

CRITICAL SOCIAL PARADIGM

Critical social paradigm or world view is one of the sciences of Jurgen Habermass' theory of human interests, which propose three sciences. Firstly empirical-analytical, which incorporates a technical interest; and secondly a historical hermeneutic, which is largely the understanding of a situation retrospectively, a practical interest. The third is the critical interest which incorporates the emancipatory interest, (Emden, 1991). Critical social theory is described by Allen, Benner and Diekelman (1986, p.33) as "the criteria that scientists use, to separate knowledge from fiction or mere belief, are always based on social conventions........ not on some transcendental appeal to facts." Allen et al. document that all theories have value interests and that while the empirical analytic theories are directed towards control, the critical social theory is inclined towards emancipation. Crane (1991) also sees critical social theory as a paradigm which could aid in the emancipation of nurses from the cultural constraints, such as power over the patient and submissiveness towards doctors. Pearson (1994) also maintains that the critical social paradigm may be useful to enable nurses to reason and react and to develop autonomously within their workplace environment and develop a "consciousness about the world" which will "empower the nurse to transform it in order achieve professional goals for clients and the community" (p.3).

Carr and Kemmis, (1983, as cited in Emden, 1991) are very supportive of critical social theory. They consider that the theory has inspired many people particularly nursing educators to examine new ideas for nursing education. However Fay (1987, as cited in Emden 1991, p.23) finds the theory weak in terms of its practicality and states that a theory cannot be both "scientific and political". Fay also believes that the ideals of critical social theory are unpersuasive, as they overstate the "power of reason" and consequently are "partly to blame for such degenerations into oppression" (p.24). Fay is joined by Hickson (1990, p.10) in believing that "missionary zeal" or one sidedness could lead to the nursing profession losing direction and replacing "one kind of oppression with another". Hickson (p.11) continues to say that "critical theory does not promise us (the nursing profession) an easy path to freedom from oppression".

REFLECTION

Critical social thinking can be a difficult and sometimes painful path to follow as it often threatens what little security we have (Case, 1994). As potential practitioners of critical social theory nurses have to be very sure of their facts when they are challenged on a theory or plan of action by other members of staff. In order to feel comfortable with propounding theories, reflection and research are important. Changes are occurring in the area of education in order to develop nurses of the future who can practice in a profession that still has a sense of identity and will cultivate interest in the potential of reflective practice. As Emden (1991) states "Current interest by nurses in the potential of reflective practice is an indicator of nursing's quest for self understanding" (p.11) Nurses need to examine the relationship changes that will occur as a result of working within the critical social paradigm in order to avoid major conflict between the 'old' and the 'new' ideals. Bevis and Watson (1988, as cited in Crane, 1991, p.404) are quite clear that "learners engaged in processes within the critical paradigm will need support in differing ways from their educators". Students will learn in a different way and will become more demanding as they develop within the new culture of learning (Alshuler, 1986, as cited in Crane).

Is it my imagination, or am I becoming more argumentative?

The current way of practice is doing things "because it's the way we are told to". There seems to be no room to *individualize care and use our, not insignificant, brains.*

(Personal Journal Entry).

> As has already been noted, the threat to our personal security, caused by reflection on our practice can be a painful experience. As Case (1994) says, it is easier to be told what to do in our professional role, and Chesney (1996, p.8) believes "the potential for learning from actual and sometimes painful experience is lost or buried if the practitioner does not reflect upon the incident, or there is no way in which it can be shared". If we cannot discuss ideas or incidents no one will learn from the observations made. There needs to be a cultural shift in the working

environment as new students are often unsupported and their thinking is often misunderstood by the resident nursing staff. Townsend, (1991) notes, constant reflection on the learning process, by students, was essential to the changing of behaviour and the 'letting go' of old ideas (p.129).

REFLECTIVE PRACTICE

"Adherence to the critical theory paradigm also requires subsequent transformative action to be taken" (Speedy, 1991, p.199). Transformative action usually follows practice in reflection (Street, 1991). That can be reflection in action, as a task is performed, or reflection on action, as in examining the events of the duty, or debriefing. Reflection is aided by journaling, which provides a written record. As Street (p.384) notes "Engaging in discourse with our journal has the power to transform our consciousness both in relation to self understandings and in terms of situating nursing within the social, political, and cultural contexts in which nursing occurs." Either during work, or at the end of the day the nurse can be reflecting on the events of the duty. Street maintains that nurses often work on 'auto-pilot' so that they maintain control over the workload. In order to empower nurses, work needs to start on reflection of practice to begin the process of challenging and changing the status of nurses. Street continues, saying that living in the past does not encourage critical reflection because the memory becomes distorted and inaccurate. Reflection needs to be on current practice. As Hickson, (p.384) states "we are in control of our destiny if only we can recognize that we are able to act, not just react."

Benner (1984) believes that all levels of practitioner can benefit from reflective practice. Chesney (1996) endorses this statement claiming that reflecting can come from all levels. Any practitioner can reflect on the practices they observe and gain from the experience. This is evident in my personal journal entry;

Thinking back to when I worked as a nurse on a surgical ward, since I became a midwife, I was able to see how skilled and confident a practitioner I was. On the ward I was learning new skills and had to check each move that I made. Where-as in midwifery I could enter a room and see, almost at a glance what was needed or happening. It was a good experience for me as it reinforced to me where I belonged and how much more valuable I was as a midwife rather than as a nurse.

(Personal Journal Entry.)

Street (1991) likened the complexities of nursing to the untangling of a skein of wool. Each thread has to be loosened gently and tested for integrity and strength. Some will break under the strain. In order to identify and follow each piece of 'wool', the details of the nurse's working life need to be recorded so that events and emotions can be identified and examined. Nurses are being encouraged to take notice of some of the practices that are so routine (Parker & Gardner, 1993). Nurses need to begin to observe the "invisible". Nurses familiarity with birth and death processes may have the potential to minimize their human significance. We need to record how we feel at such events and examine whether we can improve our interpersonal skills with our patients. Nurses are being encouraged to journal their work experiences (Allen et.al.,1986). I believe that honesty in reflections and documentation could develop better practitioners.

CRITICAL SOCIAL THEORY IN MY CLINICAL AREA

The most fundamental aspect of critical social theory is the question of whose interests are being served (Street, 1991). This theory has been used as the basis for social and political change in the area of childbirth. Research by Middlemiss, Dawson and Gough. (1989) and Oakly, Rajan and Grant. (1990) as cited in Sandall (1995) have demonstrated that centralised maternity units offer no better or no worse care than the midwife only care. These British midwives have developed the theory into practice in order to provide good care for women and babies in the community. They have documented evidence to show an increase in babies' weights, a reduction in smoking rates and greater job satisfaction for the midwives who work in the community. Sandall (1995) is also able to demonstrate that women who are considered high obstetric risks also benefit as much, or possibly more, from the continuity of care. The women continue the pregnancy to a better gestational age and have increased baby weights. The women also reported feeling more in control of their lives and more satisfied with their care. Flint (1993) endorses this research from her own experiences. Research by the Know Your Midwife group in England demonstrate better obstetric outcomes with larger babies and happier mothers.

JOURNALING

Reflection on practice and journaling would seem to go together. In order to reflect on our performance at work we need to remember what we have done. It is far better to reflect at leisure, but memories are not always accurate. Jotting down key words from incidents of the day makes reflection an easier task at a convenient time. Stories, related verbally may become abbreviated and distorted with telling and the essence of the incident could be lost. Journaling, though often tiring and time consuming for the nurse at the end of a busy day, has the value of recording events as soon as possible. With practice, the writer is able to record emotions, as perceived by the writer, of those involved in the event. These journals can then be reviewed later for analysis and learning.

From a personal view, journaling has been an effort and quite time consuming as I struggle to evaluate my

working day. However, as preparation for a course of study I became aware that I would need to journal. As I considered the concept of reflection I found myself recalling different events, and attempting from a distance to learn from them. I am now looking forward with some anticipation to reflecting on the written word.

Why is it that we insist on referring to female patients as "the girl Smith" ? Is it a feeling of power that we wield? By removing all status from a women do we then feel more in control?

(Personal Journal Entry.)

> This particular entry was an idea that I now realise, has bothered me for some time. I am now able to consider the issues raised by the idea and address them.
>
> Boyd and Fales (1983, as cited in Kirkham, 1997, p.260) suggest the process of reflection and research begins with a sense of unease or "an itch that wants scratching". Once we can identify what does not feel comfortable then we can attempt to resolve the problem. Cox, Hickson and Taylor, (1991, p.384) write "reflection assists us to identify how we are both shaped and shapers of our understandings". Journaling, Bennett (1991) writes, is an important aspect of today's nursing as it develops the skill of reflective practice and may enable the writer to identify areas that need to be researched. Journaling may reveal insights to our practice that we may not have been aware of. Cox etal. note (p.384), "we may uncover just how hard we have been working to keep things the way they are". They claim that documentation of our ideas, emotions and daily events, to be examined later, may help nursing to identify its destiny.

CONCLUSION

This article has examined some of the current literature relating to critical social theory and reflective practice To move forward as a profession, there is a belief that nursing and midwifery need to embrace these two concepts in order to recognize who they are as practitioners and to value what they do. Journaling has been seen as a useful tool for reflective practice for nurses and midwives. It could also encourage individuals to critically analyze their own and others' practice, and may assist in the growth of the profession. My personal journaling has been a positive experience to date, and this has inspired me to reflect on my practice, and, I hope produce a better nurse and midwife.

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Beginning Journeys - Volume 5

Exemplar: The Therapeutic Touch

M E Thompson Transition to Degree Nursing Student, Christchurch Polytechnic

During my learning time as a transition student at Christchurch Polytechnic, I was given the opportunity to learn and discover the art of Therapeutic Touch. This was a unique experience for me and one which I will carry with me always.

Bolstad (1990) describes therapeutic touch as a process of healing through the human energy fields. Therapeutic touch was developed in the 1970's by a nurse, Dr Dolores Krieger, based on the work of healer Dora Kunz. It has been widely taught in America and Canada. Nurses using this technique are coming up with evidence that therapeutic touch enhances healing, reduces pain and aides in relaxation of clients. Bolstad describes this process of healing through the human energy fields as the direct transmission of love from the healer to the person in need of healing. The nurse who is giving therapeutic touch must genuinely want to heal and give love. The healer needs to find awareness of their own energy field by sensing the energy flow around them and thus directing that energy flow to the client's energy field. The healer scans the client's body with the palms 5-20 cm from the client in order to sense an imbalance of energy which may be felt as coolness or heat. Close your eyes and imagine running your hands over satin and finding a flaw in the fabric. Think of the flaw as an imbalance in the energy field which needs to be smoothed away. The healer continues to sweep down the client's body from head to toe until they feel the energy flow is in balance. Think of yourself as smoothing out the satin and the giving of love and the desire to heal.

Therapeutic touch is not simple to explain in the written work, one needs to experience it to understand it. The following exemplar is my first experience with therapeutic touch which has encouraged me to use it in my nursing practice.

My partner and I were sitting by the fire just talking about things in general. I told him about my experience at polytech and how I had discovered the art of therapeutic touch. "It's hard to explain what I mean, would you like me to try it on you and see how it feels" (personal communication). He was happy to partake in this experience. I put Zamfir on the tape deck which is beautiful pan-flute music. I asked him to lay on the floor, which he felt comfortable with. I asked him to close his eyes, then I separated his feet lightly massaging them, to make my presence felt. I knelt beside him closing my eyes and placing my palms together. In order to centre myself and bring a feeling of giving love, I pictured my daughter leaving for the North Island. I could see myself holding her close and the love I felt for her overcome me. I could see her smiling face and feel the softness of her hair against my skin.

Now I was centred and aware of my own energy flow. I ran my palms without touching my partner over his body from head to toe. I found some imbalance in the abdominal area. I continued sweeping downwards with more concentration on the abdominal area. I continued sweeping until I felt the energy flow of his body was in balance. My partner became totally relaxed with a glimpse of a smile on his face. To finish I lightly massaged his feet. I asked him how the experience felt for him. He said it was very relaxing and he could feel the energy flow from my hands.

I then found myself telling my partner about my tutor at polytech and how she had opened my mind to new and meaningful experiences, which had enriched my journey of learning at polytech. I said "there is something I would like to share with you which I was touched by"(personal communication.) I then read Louise Hay's "ten ways on how to love yourself". He agreed it was a beautiful piece of writing. We then started to talk about our children who are all going through different journeys in their life. We talked openly and calmly. Usually the discus sion about our children becomes somewhat heated, as we are a step-family and life has been turbulent at times. I believe that therapeutic touch had a lot to do with how the discussion developed, we had a lovely talk and there was a feeling of tranquillity in the air. My partner then went to bed and I sat down to write about my experience.

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Exemplar: The Helping Role, The Work of Nurses in Practice

Megan Jones Bachelor of Nursing Student, Christchurch Polytechnic

Introduction

Patricia Benner (1984) based her model of nursing on the work of nurses in practice. She used the Dreyfus model of skill acquisition to show that a nurse will pass through five levels to become an expert nurse. The nurse will begin as a novice, move on to being an advanced beginner, then on to being competent, next the nurse moves on to being proficient and then finally becomes an expert.

In order to develop her model, Benner used exemplars from expert nurses. From these nurses' experiences Benner developed 31 competencies. Similar competencies were then collated and placed under seven domains of practice.

In this essay the domain of practice that will be looked at is the helping role. The helping role involves the nurse helping a client (Benner, 1984). At times this may mean helping the client through change or being with them in times of trouble. It may mean giving extra special care or simply letting them know they are cared for by touch or a listening ear.

There are eight competencies within the helping role (Benner, 1984). In this essay two of them will be discussed. The first is 'providing comfort measures and preserving personhood in the face of pain and extreme breakdown' and the second is 'presencing: being with a client'. Each competency will first be summarised and then I will share an exemplar that I feel demonstrates that particular competency. After this I will discuss the exemplar and show how it illustrates the competency.

Providing comfort measures and preserving personhood in the face of pain and extreme breakdown

In this competency the nurse 'gives up' trying to save the person's life and instead finds ways to comfort and look after the patient and their family (Benner, 1984). By doing this the nurse enhances the patient's quality of life in what is often the last days of their life.

Exemplar

My client was an 82 year old male with multi-infarct dementia. I felt saddened that a man who had done so many things in his youth was being reduced to a child again.

I knew that I could not halt the disease process. I wanted to find something that would give him joy. One of the assessments we had to do for our course was to do a social activity with our client. After reading some books on dementia and activities to do with dementia patients I thought I would get some plant books out of the library to read with my client.

I spent a lot of time trying to find an activity to do because I wanted to do something that my client would enjoy and for a little bit be the man he was before the dementia set in. In the end it became more important for me to do it for him than the assessment.

On the day I chose to do my social activity I brought the books to my client and asked if he wanted to read some books. He said "yes" and practically pulled the books out of my hand. I told him I got plant books because I found out he enjoyed gardening. He looked at me and asked "Did I?" with a twinkle in his eye and a smile on his face. This made me laugh as I realised something I did not know before, my client had a sense of humour.

We sat and just looked at the pictures for about 30 minutes. During this time my client would run his finger across the large type words and read them. He was able to follow the words in sequence. Once again my client surprised me as I saw he still had the capacity to read.

Towards the end of the book we came across a picture of mossy trees and a stream running though them. I remarked on how the picture made me think of England. I asked if he had ever been to England, knowing full well that he had. The response I got was one I will never forget. It was as if a light bulb went on inside my client. He sat up straighter and smiled. The smile was huge. His whole countenance changed. I could tell from that reaction that my client had good memories of England. I asked him about some of the places he might have been to and we had a conversation for a few minutes before he lost that train of thought.

I felt very privileged to have witnessed that moment. I am glad I took the time to be with my client and that I asked the right questions. For a couple of minutes he was the man he was before the disease and that is how I think of him when I help him with various tasks during the day.

Reflection

This exemplar demonstrates the competency of providing comfort measures and preserving personhood in the face of pain and extreme breakdown in that I tended to my client's personhood and not to the disease. I realised that I could not do anything to cure his disease but I could help him in his reality now. I could not stop the confusion but I could help stop the isolation that the confusion brings by being with him for extended periods of time. Part of this competency is realising that there is a time when the focus on the cure must stop and instead the focus becomes the patient and keeping them comfortable (Benner, 1984). I believe I achieved this by trying to find ways to help my client in his disease state and not by trying to cure his disease.

Benner states that this competency is about enhancing the patient's quality of life in the face of pain and breakdown. Most of the time my client sits in the lounge by himself with a magazine or newspaper, that has print too small for him to read. By spending some time with him I was taking away some of his isolation. By giving books that he would enjoy I was giving him mental stimulation that he would not normally have. Therefore I would have to say that in those times I did enhance my client's quality of life in extreme breakdown.

Benner (1984, p.56) states that in this competency the nurse 'contributes to and facilitates the patient's sense of personhood, meaning and dignity.' I believe that in this exemplar I do promote my client's dignity and personhood. I looked at him as a person who needed to have needs met and not as the man with dementia that did not do anything all day. By doing this I believe I restored a portion of his dignity. I saw that there was more to my client than just the blank face and I wanted to find it. By giving him books and asking questions that sparked memories I was giving him back his personhood. He did begin to remember who he was throughout the process.

I learnt a lot from this experience. One thing I did learn was that multi-infarct dementia is a complicated disease. Just because my client can often be confused and disorientated does not mean that he has lost all of his mind. At times such as in this instance, he can be coherent, read and remember events in his past.

I realised that I can not put my client in a box and think that just because he has this disease he will behave in a certain way. I am glad he surprised me because it showed me that my client is able to do more and understand more than I gave him credit for.

Presencing: being with a patient

Presencing involves being with the patient. Benner (1984) says that staying with the patient is often as important as doing things for the patient. She says that touch, person-to-person contact and allowing the patient to express their feelings are all important components of this competency.

It was my third time at my new clinical placement and I had decided that today was the day to do my client's blood pressure. My client was a 74 year old man with left hemiplegia who had a history of hypertension. I wanted to find out what his blood pressure was.

My client had other ideas. He loved company and found the difficulty of others understanding him quite frustrating. This meant that whenever we were together he wanted to talk.

This day was no exception and after we got back to his room after morning tea he pulled out an old box with coins in it. There were coins from all over the world and a couple of old English ones. I was enjoying myself and talking to him about the coins but I still wanted to do his blood pressure. At one point he stopped looking at the coins and asked me to look under some books. Under the books was a picture of a grave.

He told me that it was his wife's grave in Dunedin and that he had never seen it. "My wife's family was from down there," he said, "she was buried in the family plot." "You must miss her." I said (personal communication). He did not really acknowledge my statement instead he began to talk about how she was a nurse and what she looked like in her uniform. He told me how she would harass the nurses at the hospital when he was in there for his stroke, making sure they looked after him properly.

My client then began to tell me how she found him the first time he had a stroke. I know it still hurt him to think about it because it took him a while to get the sentences out. He told me of her anxiety to get the door open and how he could not help her open the door because he had fallen against it and could not get up. I think the thing that hurt him the most was that he could not help his wife in her anxiety. I could tell this because he kept talking about falling and not being able to get up and help his wife on the other side.

I did not speak much at all during this. I did not want to interrupt him. I could see that he needed to talk as he did not need prompting to speak of these things. I believe my presence and my listening to what he was saying helped my client continue and tell me his deeper feelings.

Reflection

Benner (1984) says that being with a patient is as important as doing things for the patient. Presencing is as one nurse puts it "really communicating" (Benner, p.57). I feel my exemplar shows that on this occasion I was communicating with my patient. I did not need to say much but he knew I cared. This enabled him to tell me about troubling experiences that he had. I feel I was presencing after he showed me the photo because my client started to talk about an incident that bothered him and I just listened.

Another aspect of this competency is the nurse allowing the patient to express their feelings (Benner, 1984).

In the above exemplar I allowed my client to talk about his feelings. He never expressed what he was feeling but I could tell by the way he was talking that he was saddened by the way everything happened. I could tell that he loved his wife because he could explain the things she did and wore in great detail. I could tell that he mourned her loss because he wanted to see her grave. I do not know if he ever talked about these things before but the most important thing is that at this time he needed to talk about them. By giving my client the opportunity to do so I was presencing.

I believe that my presence was also therapeutic. One of the reasons that I believe he told me these things is because it was me he was talking to. My client and I had built up a good relationship and he felt comfortable in my presence. He knew that I would listen and that I would not rush out of the room. Benner (1984, p.58) says that in this competency nurses need to realise the "value of their presence for their patients". I believe that I did understand the importance of my presence for my client and believe that I was presencing.

I am saddened however that at the time I was not so concerned with what had happened. I did not understand the significance of the event until I read Benner (1984). At the time I was preoccupied with taking my client's blood pressure. When I read over my journal article after reading Benner I realised that I had been presencing. At the time however I was annoyed that I had not got his blood pressure instead of being glad that he told me so many personal things.

From this one thing I learnt that it is important to have those moments with clients and allow them to ventilate their feelings. Although getting his blood pressure was important, at that time my client needed someone to listen. I cared enough to listen and he felt comfortable enough in my presence to talk about the things that were bothering him.

However I did not understand just how important these times are for a client. I am now more aware of this and am happy to allow my client to talk. Now I see that those times are just as healing and helpful and are just as important as the times that I am doing things for them.

Conclusion

Benner (1984) developed her model of nursing from practice by using exemplars from expert nurses. From these exemplars she developed 31 competencies which were divided into seven domains of practice.

In this essay two competencies of the helping role were discussed. Personal exemplars were used to illustrate each competency. For "providing comfort measures and preserving personhood in the face of pain and extreme breakdown" I used an exemplar that talked of how I looked at books with my client who had dementia. During this time he could converse with me and he seemed to remember experiences he had had. I felt that I demonstrated this competency because I focused on my client instead of trying to cure his disease. I also enhanced his quality of life, his dignity and personhood.

To illustrate the competency, "presencing: being with a patient" I choose an exemplar where my client told me about his wife and about not seeing her grave. He also told me about his first stroke and how he could not help his wife help him. I believe I accomplished this competency because I listened to my client and allowed him to ventilate his feelings. I also recognised that my presence was therapeutic for my client.

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Exemplar: Travelling On

T. Baker Bachelor of Nursing Student, Christchurch Polytechnic

Today I stood and held Mr K's hand as he journeyed along the road from earth to eternity. It was a long way and often he struggled to keep going. His breathing was labored, his pulse weak, shallow and rapid. His mouth was caked, his tracheotomy gurgled and sometimes overflowed with green pus.

Mr K has cancer in the lung and double pneumonia. He's severely malnourished his bottom isn't there anymore just skin pulled over the bone. He has a large angry-looking bedsore and the smell from his breath/tracheotomy seemed to penetrate my whole being. M and I tried to lay him down to drain his lung but he clung onto us with a terrified look in his eyes. Each time we moved him was so painful, but sometimes we had no choice. M gave him some elixir and morphine to relieve the pain.

I took a break over lunch but was shocked by the deterioration in that one short hour. His face was dark grey and very drawn. His eyes were open but only stared vacantly at nothing. His breathing was very shallow. His body didn't stop twitching, a sign his body was closing down, one of the nurses told me.

As I stood by him, I wondered what had been in his life . . . did he once have a wife and family? And if he did, where were they now? Had they predeceased him? Were they waiting at the end of the road for him? Was he lonely walking this journey of death?

I wondered if I should be talking to him, but it seemed out of place to talk about the beautiful day . . . or the TV talkback show on euthanasia. Sometimes he'd turn his vacant eyes toward me and smile and sometimes his face would be firmly set as though he was determined to finish this course. Sometimes he'd just reach his hand across the bedcovers and take mine. He didn't need me to talk . . . just to watch him as he travelled slowly on down the road.

I thanked God for this dear man who had been prepared to lay down his life so I could live in peace and freedom. What a gift! As I stood by him, holding his hand, it was as though we were only holy ground. There was a peace in the room and a respect as the nurses came and went. I prayed a blessing over him and he smiled in his sleep and gently squeezed my hand.

A young nurse came in with a loud, cheery "Here's your washing Mr K" I wanted to whisper to her "Sssh, dear friend. This man is in the process of dying. He's never walked this road before. He's concentrating on dying, not on clean washing. Please, just let him be" (personal communication).

It was a long journey and one which hadn't finished by the time I felt this afternoon. I went in to say one last farewell. He was sitting up in bed looking as bright as a button. The morphine must've kicked in because his breathing was less labored and he looked at peace. He gave me a big smile and raised his hand in farewell. I wish I could stay by his side, but I can't. "Please Lord, will you come and walk the last miles with him, so he won't be alone."

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Work & Study: The Effects on Women's Lives

Ann Blackie
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Most women undertake many roles in their lives; home maker, partner and mother. While there have been positive effects noted from multiple roles there are some women who suffer anxiety, feelings of guilt and stress from trying to combine these roles. Gendered expectations, their own, their partner's and the community's, influence women's lives and experience. The majority of women are the major care givers of children, partners and parents. Women who are in paid employment outside the home are still also responsible in the main, for the household work.

Some women who are already taking responsibility for housework and child care, and who are in paid employment, also take on part time or full time work study. These women may be our students or they may be members of our teaching staff. This paper describes research in progress which examines the effects of women's multiple roles and the expectation society has of the fulfilment of these roles. In particular, it considers the effects on women's health and lives of returning to study as a mature student.

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Health Assessment for Nurses in the 21st Century

Kaye Milligan & Stephen Neville - Lecturers, Christchurch Polytechnic

Christchurch Polytechnic is one of the few tertiary institutions in New Zealand offering courses in health assessment and physical examination skills at both undergraduate and post registration levels. In recent times there has been a burgeoning interest in health assessment courses from registered nurses. This reflects the enthusiasm for the expansion of the role of the registered nurse. Support for advanced nursing practice has been given by The Nursing Council of New Zealand in their framework for specialty practice certificates, Nurse Executives of New Zealand, The College of Nurses Aotearoa (NZ), as well as other major nursing organisations. The use of health assessment skills provides nurses with the opportunity to enhance their role as teachers/educators in any setting.

This paper will summarise the literature available on health assessment. It appears that there is a dearth of information available from a New Zealand perspective and this paper will help raise the profile for further debate. There is a multitude of terms used interchangeably with health assessment, for example physical examination skills, physical assessment, investigation of a health problem. Clarification of these terms will be provided. A practical example will be used to demonstrate the use of health assessment as a tool to monitor a client's health status by providing base line data and giving the nurse the opportunity to teach/guide/coach/educate and empower the individual to promote health and well-being.

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Ghosts of Nursing - Past Present & Future

Lynette Low, Peter Rosewell, Mavis-Jean Beynon - Lecturers, Christchurch Polytechnic

The educative role of the nurse has been acknowledged in the past as an important one in empowering others through the giving of information. The importance of this role has increased significantly with the health reforms of the last decade. The cumulative effect of the reforms has seen a paradigm shift in the delivery of health care in Aotearoa/New Zealand with regard to the onus of responsibility for health. The emphasis is now firmly on the right of the individual to self determination with complete autonomy to make decisions on their health. This paper will look at whether all nurses can be educators in light of the above changes. In order to meet the educational needs of people from increasingly complex situations the presenters argue that an awareness of self and a committment to self growth is required. A framework will be used to explore these concepts. It is suggested that the idea of nursing as a career based around catering to/ administering to and providing to the needs of others may attract some people into it who have a need for ongoing spiritual and emotional support. Whether nurses with these unrecognized and unmet needs can fully facilitate the educational needs of the client group they work with is questioned. Nurses as educators promote holism as a transformative process. Recognition of where we come from personally and as a profession can be fully utilized when we value ourselves primarily as agents of our own healing. Then, and only then, can we truly facilitate and promote the process of anothers healing.

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TO PREACH OR NOT TO PREACH: THE EXPERIENCE OF PROBLEM BASED LEARNING

Jackie Walker, Rose Mitchell - Lecturers, Christchurch Polytechnic

The complexity of client's health needs today requires an integrated approach from nurses in practice. It follows that nursing education should prepare students to nurse their clients holistically. This requires an holistic approach to the processes of learning and the use of problem based learning in a scenario format is one such approach. This paper will address issues related to problem based learning from both the learner's and the educator's perspective. We will give an overview of the format used in this approach at the School of Nursing at Christchurch Polytechnic and identify the principles of teaching holistic nursing care. In particular, we will discuss student's responsibility for their own learning, the assessment of learning, and the educator's role in facilitating the learning process. The implications of this learning approach for student's preparation for clinical practice will be raised. We will draw on our experiences over the last three years in teaching Bachelor of Nursing students and share both the advantages and the strategies we have developed to maximise this learning process. In our presentation we hope to involve the participants in discussing the issues raised.

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COLLABORATIVE EDUCATION - WHO BENEFITS?

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A Nursing Outreach service specializing in Respiratory Nursing provides clinical placements for third year nursing students undertaking a Bachelor of Nursing degree. The nurse clinician's desire to embrace change and practice holistically provides an environment that not only encourages critical thinking, but also fosters the expectation that students will be actively involved in both teaching and learning. Students' participation in staff teaching as well as client education emphasizes the importance of and value of lifelong learning. The symbiotic relationship inherent in this collaborative educational process benefits students, nurse clinicians and nurse educators. Examples of student's participation in staff education will demonstrate and acknowledge the invaluable contribution this process has for all participants.

Future trends within the nursing profession are dependent on collaboration between practice and education. The burgeoning trends of integrated or managed care, particularly in the community and in primary health, demands attention from nurses who wish to be part of a dynamic profession prepared for the challenges of the new millennium. Ensuring the profession can prepare graduates capable of embracing these emerging roles necessitates an educational programme that is practically based and exacts intellectual challenge. A collaborative approach to nursing education incorporates both concepts. Providing a perspective from both practice and education, this paper will discuss the reality and benefits of such an approach.

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Preparing for the Next Millennium

New Zealand Informatics Conference 27-28 August 1998, Auckland

Elizabeth Hanley - Lecturer, Christchurch Polytechnic

New Zealand Health Informatics Foundation and Nursing Informatics New Zealand jointly hosted this conference. Its focus was on preparing for the next millennium by adapting to and embracing the Communication Age. Nearly 100 people attended, with most people coming from the Auckland area. Presentations covered a wide range of information about Informatics from a past, present and future perspective.

Keynote speakers

Professor Michael Brittain, Victoria University of Wellington spoke on A Review of Some Recent Issues in Health Informatics, in the Context of Evidence Based Medicine. The main focus of this paper was on recent developments in health informatics in New Zealand and Australia. We are still behind Australia in some areas, which Michael related closely to the limited dollar for health in NZ. In the major institutions progress has been greater with patient management systems installed and various links to other applications such as pathology services and telemedicine, particularly for radiology services and dermatology.

Professor Robert Greenes, Harvard Medical School, via video conference spoke on Millennium Changes in Health Informatics. (This was my first experience of video conference and I was really impressed by the people involved in setting up the link and streamlining it for our purposes.) Robert's dynamic presentation looked at the forces of change in health care; specific information needs for health providers; and the components-based approach used at Brigham and Women's Hospital. The important point he made was that the components-based system works well as long as it is an integrated system and all the applications can easily "talk to each other."

At Brigham and Women's Hospital a Decision Systems Group has been established, supported by grants and external business, to research and design improved systems and integrate a logical web environment for client assessment, diagnosis and education.

Professor Kathryn Hannah, University of Calgary, described From Nightingale to Networks looking at the changes in Nursing and health care. The main focus of her paper was on the management of health information and the importance that nurses define nursing information needs. Nurses must then progress to the effective nursing management of information. She emphasized the responsibility of nurses is to ensure that health information is managed wisely.

David Warner, Director for Interventional Informatics, San Diego via teleconference, presented an exciting and dynamic discussion on The Future of Interventional Informatics. This introduced us to the not too distant future where multimedia information supports healthcare at every level from client to consultant, with other health professionals having access to a certified bank of multimedia expert support.

Workshops

It was interesting to hear from *Michelle Honey and Jenny Collard-Scruby* about the development of the Plunket database as this is being instituted in the Southern Region at the moment.

Robyn Carr discussed her role in Auckland Healthcare Services Ltd. and the implementation of a patient management system. She clearly supported the need for a structured project management system with a person designated as Project Manager with the time and resources required for this task.

Catherine Rennolds, currently employed at UNITEC, spoke on the Print Digital Shift in Education. Catherine's role is to promote this move and develop a seamless learning environment which, removes the barriers to learning. For this to happen, she says, we must be innovative in our delivery of education using the whole range of flexible delivery modes.

Heather Moore also from UNITEC talked about her Vision Toward the Use of Technology in the Education and Practice of Nurses. Heather looked at the constraints and practicalities of embracing technology in nursing practice and further developed the concept of a seamless learning environment.

Bev Johnson, from Manukau Institute of Technology, took this a step further and described the development of Distance Education for Practice Nurses and stressed the importance of multimedia communication for students.

Dr Peter Schloffoel, from Trident Health Australia, presented the final workshop. Peter provided a very stimulating walk through the development and implementation of an Electronic Health Record (EHR). He highlighted the need for health IT standards with reference to EHR architectures.

Posters

Posters covered the topics of Tele-dermatology, NZ standards in healthcare, and compiling a data dictionary.

Conclusion

I appreciated the opportunity to attend this conference as it provided me with the chance to network with other nurses involved or interested in Nursing Informatics and to learn from others the direction that Health Informatics is taking as we progress toward the next millennium.

The conference workshops affirmed for me that the direction we are taking with distance learning is in line with current thinking and movements in education. We need to remember that education is now a global business and that the Information Age is passed. We are now in the Communication Age.

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5th International Qualitative Health Conference

7 10 April 1999 The University of Newcastle, New South Wales, Australia

Cathy Andrew, Lecturer, Christchurch Polytechnic

This multi-disciplinary international conference was attended by over 350 delegates from countries including Australia, New Zealand, United States, Canada, United Kingdom, South Africa, Korea, Thailand, Mexico and other European and South American countries. Although the majority of delegates seemed to be nurses, there were also doctors, psychologists, anthropologists, optometrists and academics from a range of health-related disciplines.

Prior to the conference I was able to attend a half day workshop with Professor Max van Manen (Canada) who is a world renowned expert on qualitative research, particularly phenomenology. The workshop focused on using writing-as-description/interpretation and explored issues relating to analysis and writing-up of qualitative data.

The keynote speakers contributed a range of views and challenges regarding the actual and potential contributions of qualitative research.

Lenore Manderson (Australia) presented methodological issues and findings of Australian health research with indigenous women and immigrant women from the Philippines and former Yugoslav republics. This held particular significance given the present war in Yugoslavia.

Janice Morse (Canada) encouraged researchers to consider investigating illness and injury with disenfranchised members of society such as the critically ill and dying. She identified restrictions arising from the context and participants, and the ramifications on research design, data collection and analysis.

Margaret Sandelowski (USA) gave two keynote addresses. In the first she critiqued technology as a cultural instrument using fetal ultrasoundography as an example. She described how technology has been used in a physical and material sense but then expanded to look at its impact on the birth experience of women. In the second keynote address, she explored the role and potential roles of qualitative research in the era of managed care where measured outcomes of intervention are required.

Max van Manen (Canada) presented a view of caring. He explored the word 'caring' emphasizing its translation to Dutch and German into 'caring-as-worrying'. He illustrated this by describing the parent-child relationship and the experience of the caring parent. This provided an interesting and challenging extension to traditional views of caring that have been expressed in the nursing literature.

William Miller and Benjamin Crabtree (USA) provided an audio and visual "extravaganza" with their presentation exploring 'the evidence that really matters'. They identified cultural assumptions of qualitative research that they warned puts it in an addiction / dualism model. They used the term 'earth jazz' for suggestions to help qualitative researchers reconnect with the body as a whole and to the earth.

In addition to the keynote speakers, there were 12 concurrent sessions where delegates could choose to attend a range of topics including summaries of qualitative studies, issues in qualitative research and methodological issues. Many of the sessions were excellent and provided a truly multinational, multi-disciplinary perspective.

My thanks to the Christchurch Polytechnic Academic Board Research Committee for support to attend the conference and deliver a paper in the concurrent sessions.

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The Pride & Passion of Professional Nursing Practice

The College of Nurses Aotearoa (NZ) Conference 8 & 9 October 1998, Rotorua

Ann Blackie, Stephen Neville, Kaye Milligans, Judy Yarwood - Lecturers, Christchurch Polytechnic

Four members of the School of Nursing represented the Faculty of Health & Sciences, Christchurch Polytechnic at the 1998 biennial conference of the College of Nurses Aotearoa (NZ) held in Rotorua. The conference was opened with a powhiri. Our welcome was particularly significant as Puti Puti O'Brien, the Maori patron of the college, was present. For many of us this was the first time we had ever met her and we were impressed with her wisdom and support over the two days the conference ran.

Cathy Cooney and Jenny Carryer (the executive director of the college) set the scene for what was to be a stimulating conference by introducing "The Pride and Passion of Professional Nursing Practice" with enthusiasm and several challenges. The key note address was provided by Phillida Bunkle, Minister of Parliament for the Alliance Party who spoke on "Building the environment to support the pride and passion of professional nursing practice." Content of the opening address surrounded economic constraints, matters relating to health and safety and barriers to best practice for nurses all framed within a sociopolitical context. Lively debate occurred between the floor and keynote speaker as not all people agreed with her comments relating to the Ministerial Taskforce Report on Nursing.

A wide range of concurrent sessions were available for delegates to attend. These included:

- "(Re)searching for the x factor. Talking about and identifying excellence in nursing practice" by Shelley Jones
- "Millstones or milestones? Developmental moments in the life of families with eating disorders and their treatment" by Jenny Meyer
- "Cultural safety. Where to from now?" by Aroha Fitzpatrick
- "Through the looking glass" by Denise Wilson
- "Evidence based practice from a health promotion perspective" by Trinie Moore
- "Te Tiriti o Waitangi. Tikanga Arotake/Whakaritenga (cultural needs assessment)" by Patricia Siaosi

The following poster displays were available over the duration of the conference for viewing. These included:

- "Student stress - nurturing our young: recommendations for nurse educators" by Patrea Anderson
- "Towards partnership for praxis" by Wendy Booth
- "Wound management by distance education" by Nina Hill and Jenny Phillips
- "People are people no matter how small: putting a theory of human resource development into practice" by Christine Mercer
- "Snapshot of paediatric nursing 1960-2000" by Judy Smith

Jenny Carryer, the Executive Director of the College spoke and challenged nursing on "Where to post taskforce?" Jenny's address gave each of us much to think about in terms of the potential future direction the profession of nursing could take and warned that our lack of cohesiveness and support of the Taskforce recommendations could be detrimental to nursing in the 21st century. Rose Pere, a well respected educationalist followed. The title of her presentation was "acquiring pride and passion in our lives." This session was one of the highlights of the conference as Rose Pere was a passionate and humorous speaker. She used her own life experience to get her message across, which was, always be proud and maintain a healthy balance between our personal and professional lives.

The first day of the conference was concluded with a well attended AGM where several important remits were passed. Several stimulating debates took place, for example, the role and status of student nurses within the college structure. On this issue it was decided that future discussions were required and the college board was charged with investigating the matter further and reporting back to the membership. It was agreed that Christchurch would host the conference in the year 2000 with Wellington potentially running a conference in 1999 as it was suggested that the college conference, in future, should be run on an annual basis. Pre-dinner drinks and the conference dinner followed the AGM.

The second day commenced with Elizabeth Percival, Chief Executive Officer of the Australian College of Nurses, presenting a paper titled "Developing a professional organisation." We enviously listened as

Elizabeth outlined the rather affluent status of the Australian College. However, our Australian counterparts faced different challenges to us in New Zealand, for instance, meeting the needs of nurses where different states have separate regulations regarding registration. One of her pearls of wisdom was the importance of being financially viable in order to contribute a variety of benefits to nurses as well as having an appropriately prepared group of people who are able to meet both professional and the political agendas surrounding nursing and health care. This interesting session concluded with a commitment from both organisations to work together for the benefit of the profession.

Barbara Docherty followed Elizabeth with "The future of funding in nursing services in Primary Health Care. Will it mean 'patch protection' or 'collegial chums'? Barbara is the Editor of the Primary Health Journal and discussed several concerns and challenges currently facing nurses working in the primary health sector, particularly practice nurses. One prominent issue facing practice nurses today is the under utilisation of their expertise.

Another excellent selection of concurrent sessions were available for delegates to attend.
These included:

- "Decision making the explicit evidence based way" by John McArthur and Annette Dixon
- "A nurse in middle management. Maintaining the pride and passion" by Maryanne Sweeney
- "Nursing Informatics: a clinical tool" by Moya Conrick
- "The practice management framework: an approach to health care delivery in entreprenurial nursing ventures" by Melanie Moorcroft and Erica Kamp
- "From apprentice to advisor: forty two years of nursing" by Gay Hayes

The second and final day of the conference was concluded by Jenny Carryer with a presentation titled "Advancing the pride and passion." Jenny, a member of the Ministerial Taskforce on Nursing, discussed the report and the associated disagreement with and withdrawal of the New Zealand Nurses Organisation from the process. The speaker encouraged nurses to continue to critically analyse and debate issues related to nursing and health care but these debates should move nursing forward not backward.

The conference was an energising experience with plenty of opportunities to network with other nurses, catch up with old friends, as well as meeting many new and interesting people in a caring environment. Several delegates attending the conference were not members of the College of Nurses Aotearoa (NZ) which highlighted the inclusive nature of the organisation as well as a commitment to professional representation of our profession.

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Beginning Journeys - Volume 5

Evolving a Shared Sense of Our Future

Waiora: Nursing Research In Aotearoa/NZ 26 - 27 March, Wellington

Kirsty Henderson Bachelor of Nursing Student, Christchurch Polytechnic

Sponsored by the Christchurch Polytechnic, I attended a conference in Wellington on the 26-27 March 1999. The conference was titled "Waiora: Nursing Research in Aotearoa/New Zealand. Evolving a Shared Sense of our Future", and was hosted by the nursing research section, NZNO. It presented a selection of the nursing research in New Zealand which was extremely interesting from a student perspective. I would like to extend my thanks to Christchurch Polytechnic for sponsoring me to attend.

The following is a personal account of the two days.

Dear Diary

0600 hours - an early start to get to the research conference in time. I'm not even sure I want to go, I've never been to a conference before and I'm nervous. Will the issues discussed be my issues? Will it be relevant to a nursing student?

1230 hours - The conference is going well but what has struck me the most so far is how real it all is. It's common sense stuff, that works with a nurse's experience and even as a student I have a little of that. Irihapeti Ramsden in her keynote address told us how important nursing research is as it provides us with power to change and validate our practice. It is not until we have the facts that we will be able to prove ourselves. There are also myths we need to destroy with research, as research is a searching for the truth. Irihapeti also said how unique New Zealand is and how much we have to offer, but because we are unique we need to do research in New Zealand as we are different.

1530 hours - It makes the research so much more lifelike to be able to see the researcher! They can explain what it means to them and some of their enthusiasm "rubs off." You get to see who will teach this material and what strikes me is how important this research can be. There was even some tears in one of the research papers presented, as one woman thanked the researcher for her work in a time when the research was difficult and for the difference she perceived this to have on her and her family. It was moving to see as it was not just class stuff but something that made a difference to people's lives. It was seeing a new side to research I had never tried to see.

Dear Diary

1000 hours - well it has been a busy morning going to the nursing research section AGM and breakfast, then straight onto the conference. Again, it was interesting to see the people who discuss the topics are real people. I never thought of research in terms of ..... people, just words, but again it's not only about academic stuff it does tie directly back to practice. I look forward to some of the discussion today. It's great to see and hear people's comments on the research and everybody is thinking critically and is really enthusiastic as well.

1230 hours- In Pamela Wood's presentation I began to see how broad research could be. I realised that you can research history, and find out how nursing care has changed over the years. Nurses were seeking knowledge and doing research years ago, although we seem to think it is a very recent thing. Comments after this talk were great. People said that the energy and enthusiasm in the room about the history of nursing made us feel proud to be here, and united us as a group. The room was buzzing with people sharing past stories on nursing. This was so new - was this research?

1530 hours - This afternoon's presentations led me through so many feelings ! I was again struck dumb with still what I thought research "should" be and it was not. In a paper presented by Ann McCleland on the experiences of nursing students, I was amazed as her research identified and discussed the strong issues that I face as a nursing student. It felt so accurate that it was as if she had read my thoughts. She talked about the marginalisation students feel, the fact that experience is so important, the pressure of assessments, and the problems students have when we go into practice settings where our buddy nurses can be a challenge. I was so amazed at the reactions of the people in the room - some bristled at comments made, while one nurse stood and said that "these are the future nurses and we have to do all we can - we really don't think how we affect them". I wished at this time my friends could have heard that! I think it would have been good to have more students present so that I could have conferred a little more with them.

1800 hours - well I'm off home now. I will be glad to get back home but this conference has certainly changed some of my perceptions on research, and the researchers. I tried not to let it change me but you cannot fail to see a new side to things when you begin with only a limited view of research. I will never be able to pick up research and say someone must have been bored with nothing to do. Research seems hard work but then all those researchers do it for a reason, and thank goodness for nurses that they do.

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MIDWIFERY CONFERENCE

Claire Russell Third Year Midwifery Student

The Christchurch Polytechnic midwifery students would like to thank the Polytechnic for their financial contribution in assisting students with the cost of attending the national midwifery conference in Auckland last year. After nearly one year of fundraising and seeking sponsorship 22 students (16 second year and six first year) were assisted to attend the conference in Auckland.

Report on Midwifery Conference, August 1998

The 5th New Zealand College of Midwives National Midwifery Conference was held at the Ellerslie Convention Centre in Auckland on 27 to 29 August. "The journey from past to future - a decade of change" was the theme that celebrated ten years of radical changes to the way midwives are able to practice in New Zealand.

Conferences are a wonderful environment for students to learn, challenge and be challenged, build networks and develop a vision. The range of speakers and our personal contribution certainly ensured this happened. Over a period of three days 23 papers were presented on a wide variety of topics. These included issues surrounding informed consent, clinical practical guidelines; a fresh approach to pain in labour; midwifery care of women considered to be at risk; breast feeding research; assessing the progress of labour; feminism and midwifery, developing personal and professional portfolios, research on making decisions in midwifery; prescribing oral contraceptives; standardising the teaching of neonatal resuscitation and others.

Christchurch Polytechnic was well represented at the conference. The midwifery tutors presented a paper on the 'pathogenesis of breast feeding' and the students presented a paper entitled "talking the Walk". Through the use of role plays and songs written specifically for the conference by students we explored what it meant to be a student on the journey to autonomous midwife and some of the positive and negative aspects of this journey. It was an enjoyable challenge creating a presentation that encompassed 22 students and three tutors and utilised individual talents collectively. We all learnt alot through the process.

Our presentation lasted 45 minutes and gave students valuable experience with the process of planning and presenting at a conference. The audience was very challenged and much discussion and debate followed, particularly amongst students from other Polytechnics.

This is the first time students have presented at a national midwifery conference in this way and we were thrilled with the impact we had. We challenged the organising committee to set up a student forum at ensuing conferences so the student voice can be heard and an opportunity to develop important skills. To our knowledge the conference at Waikato next year has accommodated this request.

We all came home focused and excited about our chosen profession, having increased our knowledge, developed new skills and established networks within the midwifery community on a national basis.

We are very proud of the Bachelor of Midwifery programme at Christchurch Polytechnic and feel privileged to be a part of the best midwifery programme in the country.

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