Re-appraising Nurse Education

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Abstract

The history of nurse education is one of conflicting claims regarding what it is a nurse *needs* to know. Perceived deficiencies in standards of nursing care, whether in the past or present, have often been attributed by medical doctors, those responsible for policy at governmental level, the media and the general public, as resulting from either a deficiency, or perhaps too great a proportion of 'theoretical', 'practical' and 'moral and spiritual' knowledge in nurse training curricula. This thesis is concerned with tracing the history of the debate through examining the evolution of nurse education policies and the discussions which have shaped them. The analysis is carried out within a framework constructed using all three 'types' of knowledge which are later analysed to determine what they might mean particularly in respect of nursing practice.

As part of the assessment of the merit of the arguments regarding the weight to be given to these forms of knowledge in nurse education, the issue of what a contemporary nurse might *be* and therefore need to know is also addressed.

Finally, and despite an initial tacit acceptance of the existence of these distinct 'types' of knowledge, this thesis raises questions about whether knowledge *can* be divided in this way. It argues that to do so is, at best, unhelpful and constraining in the designing of curricula for the education of nurses - indeed at worst, it is divisive of the profession and its educators and may have negative implications for the welfare of patients.

Contents

Chapter 1: Educating Nurses: Historical Perspectives

Introduction		1
1.1	Origins	1
1.2	The Influence of Christianity	6
1.3	The development of 'modern' nursing during the nineteenth century - the influence of Florence Nightingale	10
1.4	Nurse education policy at the beginning of the twentieth century	21
1.5	1921 – 1948	26
1.6	1949 – 1989	33
1.7	'Project 2000' to the present day	38
1.8	Conclusion	47

Chapter 2: The Nature of Nursing Knowledge

Introduction		50
2.1	'Theoretical' knowledge	51
2.2	'Practical' knowledge (knowing how), Knowledge in the hands	60
2.3	Moral and spiritual knowledge	71
2.4	The nature of knowledge – key nursing texts	81
2.5	Conclusion	91

Chapter 3: What is a Nurse?

Introduction		93
3.1	Media representations of the nurse	94
3.2	The views of nurses	111
3.3	The views of policy makers	120
3.4	Conclusion	125

Chapter 4: Re-appraisal

Introduction		127
4.1	The (uneasy) relationship between theory and practice in nursing education	129
4.2	The problem of language	140
4.3	Theory and Practice – a re-appraisal	142
4.4	The place of moral and spiritual knowledge	149
4.5	Towards a more holistic approach to (nursing) education	153
4.6	Some implications of the study for contemporary policy and practice	159
4.7	Conclusion	166

References 169

Chapter 1: Educating Nurses: Historical Perspectives

Introduction

This thesis is concerned with the education and preparation of nurses for practice, something which has been the subject of debate and controversy from both within and outside nursing throughout its history. That controversy has largely centred on what it might be that nurses *need to know* and is, of course, inextricably linked with the question of what *is* a nurse - what is it that they do? What nurses need to know, both historically and at present, appears to have been framed in terms of three apparently competing 'types' of knowledge, theoretical knowledge, practical knowledge (including practical 'skill', an aspect of practical knowledge analysed in chapter 2), and moral and spiritual knowledge. The following chapters trace the history of this debate and its influence on nursing education (chapter 1); analyse further what these descriptions of knowledge might mean (chapter 2); and consider their value in the context of both images of nurses in popular culture and the contemporary reality (chapter 3). Finally, chapter 4 will articulate some of the implications of these findings for the future development of nurse education.

1.1 Origins

Nursing is inextricably linked with ideas of caring, whether of children, older people or the sick. It conjures up an image of a warm, compassionate, and almost inevitably female person perhaps breastfeeding a baby ('nursing' in common parlance, even today), feeding a frail parent or grandparent, bathing, dressing and 'nurturing' sick relatives and perhaps even other members of the community. Jane Salvage (1985) notes that the idea of nurturing is central to the role of the nurse in that it reinforces a link between nursing and mothering and is aptly illustrated when, as she puts it "...we use the word 'nurse' metaphorically, such as in 'nursing a grievance' – nurturing feelings in the very core of our being" (p1).

The vast majority of such 'nursing' activity was, and is, undertaken by people who have received no or very little instruction or education in respect of their nursing work, whether paid (as health care assistants) or unpaid. Indeed I will analyse what might constitute a 'nurse' in contemporary parlance later in this thesis. However, this first chapter is concerned with the history of the preparation of the trained nurse - the only person allowed in law to use the term 'nurse' to describe themselves (Nurses Registration Act 1919). (Nursery nurses require the prefix 'nursery' to remain within the law.) In order to shed light on the development and role played by the three bodies of knowledge, i.e. *theoretical knowledge, practical knowledge* (including *practical skill*), and *moral and spiritual knowledge,* I will trace the development of nurse education policy paying particular attention to the arguments surrounding the weight given to them in nurse training programmes.

It became increasing apparent when researching pre-Christian and even pre-Enlightenment 'health care' (to use a generic term) that the boundaries of what might today be regarded as 'nursing', 'medicine' and 'religious ritual' became increasingly blurred. As a result, I have had to adopt a wide interpretation, perhaps one wider than Florence Nightingale may have been comfortable with but certainly little wider than the contemporary nursing role. Although the link between the nature of knowledge needed to carry out these ancient practices and the nature of knowledge required by contemporary nurses may initially appear tenuous, I justify their inclusion on the grounds that the holistic nature of some of these healing practices will be more familiar to twenty first century nurses than those trained by Florence Nightingale.

Moral and Spiritual Knowledge

Perhaps unsurprisingly, the further back in time the analysis reaches and as the level of evidence-based knowledge of human physiology is identified as more rudimentary, the greater the emphasis writers and practitioners appear to place on the moral

probity and spiritual knowledge of healers. I am certainly not suggesting at this point that the link between scientifically generated knowledge and that of moral and spiritual training is one of a *necessary* inverse relationship, but that knowledge with a religious underpinning would appear from the literature reviewed to be pre-eminent until at least the 17th century. It was then, for example, that William Harvey published the first description of the (hitherto speculative) role and function of the heart and blood vessels. His *"An Anatomical study of the Motion of the Heart and of the Blood in Animals"* was published in 1616.

Guenter Risse (1999), in his history of the evolution of the modern hospital, traces the siting of healing practices and care in classical Greece and Rome to a framework of religious cults, rituals and institutions, and notes the pre-eminence of the 'spiritual dimension' in the healing process. He describes the cult of Ascelepius, the Greek 'healing god' and the inscription on the Ascelepieion (healing temple) at Lambaesis, "Enter a good man, leave a better one". Interestingly, some aspects of his narrative cited below may resonate with those familiar with the writings of Florence Nightingale, and indeed anyone with any recent experience of hospitals either as employee or patient:

> Every healing act is a mystery. The organisation of rituals in places such as the Ascelepia was in consonance with traditional temple routines guiding the interaction of the sacred and the profane. Access to the sanctuary was linked to notions of Greek piety and purity, with strict regimentation of dress and conduct. Ambulatory supplicants followed prescribed bathing and prayer formulas. A priestly caste of attendants followed a rigid set of daily scheduled observances....similar objectives could be achieved in the military and perhaps slave *valetudinarium...* feeding, bathing, wound dressing, or drug prescribing routines, and perhaps even prayers followed. Language, symbols, music, and costume all worked together to establish and enforce social cohesion among the ill. In both venues, faith and emotion must have been critical factors facilitating recovery (Risse 1999, p58).

Risse, a medical doctor, arguably appears to find it difficult to differentiate between the work of what he might term 'healers' and nursing practices, for which the majority

of his work he tends (at first sight) to ignore. He notes the "...limitations of the healing art..." (p59), again presumably as a consequence of ignorance of the workings of the human body, and he ascribes the confidence of the sick to their hope in supernatural power and the practical skill of 'surgeons'. The other 'healing acts' described in the quotation above, those of feeding, bathing, wound dressing, drug routines and even prayers, I as a nurse would describe as 'nursing' and moreover, particularly (but not exclusively) in *this* historical context, nursing in a holistic manner inseparable from the moral and spiritual dimension of human experience. I would also suggest Dr. Risse's historical analysis, though skewed towards the history of those he also terms 'physicians', reinforces the long history of emphasis placed on the moral and spiritual component of healing and 'healers' and the acquisition of moral and religious 'knowledge' and practices, something also seen in the later work of both Florence Nightingale and more contemporary authors. The pre-eminence of religious influences and the siting of curative practices in religious institutions, arguably also reflects the lack of alternative secular structures which could perhaps practically have only been provided within the economic and social organisation of a 'nation' state.

Theoretical and Practical Knowledge

Risse describes some healers as 'physicians' or 'surgeons', and others as 'charlatans'. He notes that Galen's solution to the problem of 'quacks' and 'charlatans' was to advocate the aggressive questioning of 'would-be healers' on their supposed competence, this was on the grounds that there was no recognised training to which such practitioners could or would subscribe. In the absence of a recognised body of knowledge it could be argued that Risse's terminology is arbitrary and serves only to confuse, particularly when attempting to determine the role or even existence of 'nursing'. For example, he describes the healing community in Ancient Greece as including informal family 'care', consisting of emotional support and nursing care - a labour of love "(and)... itinerant diviners, herbalists, or root cutters, midwives,

gymnastic trainers and Hippocratic healing craftsmen. There is even evidence of patients' visits to *physicians'* homes [my italics] ...for further advice" (p28). Each of the above 'healers' (formal and informal) could be expected to possess their own body of theoretical knowledge and practical skills, perhaps not based on the results of Enlightenment principles of scientific enquiry but nevertheless requiring the application of such knowledge to practical situations. Risse describes the then common belief that the body was composed of humours, which in health were maintained in a state of balance. Ill health was caused by an imbalance of humours and therefore the remedy was to purge the body of the problematic excess through the use of emetics, diuretics, expectorants or bloodletting for example. If the removal of excess humour or poison could not be accomplished by these means, the skin could be used:

> To accomplish their goals, healers massaged, irritated, scarified and burned the skin, then employed cups or leeches, blisters and running sores to extract the offending poisons from the vicinity of vital internal organs. The expectation was that, once herded into discrete but far less dangerous blisters, pustules and abscesses nearer the surface of the skin, poisonous humours became visible to the practitioner, who could promptly drain them (p20).

Summary

The siting of the practice of healing in places of religious significance, the reliance on ritual and the importance of the spiritual probity required by healers, whether (in our terms) doctors, nurses or a practitioner combining aspects of both roles (as we would understand them) is evident. The requirement for practical knowledge by the healers is also apparent, but the mode of acquisition and by whom is ambiguous. Nightingale however, as will be seen later in this chapter, would arguably recognise many practices as falling within the remit of at least the 19th Century nurse.

1.2 The Influence of Christianity

Moral and Spiritual Knowledge

The links between healing, religious principles (here, those of Christianity) and religious institutions, continued into the Christian era. Risse (1999) argues that "The mutual love between God and humans was distinct to Christian dogma and energised all actions aimed at assisting others" (p73). Christianity, he writes, unlike the Greek and Roman religious obligations of reciprocity, was based on scriptural injunctions to help the sick and those in need.

Ann Bradshaw traces the majority of what shall be termed *formal,* perhaps even *institutionalised* nursing to distinguish it from care given by family members, to medieval Christian religious orders and charities (Bradshaw 2001a). However, despite (or perhaps as a consequence of) being a nurse herself, she does not define what she means by 'nursing' either in the medieval or early modern periods and is unusual amongst the authors reviewed here in using the term at all. Risse (1999) also sites the growth of health and social care in religious institutions as the Christian ideal of charity "... energised all actions aimed at assisting others" (p73).

The religion may differ from that of classical Greece and Rome, but the presence of 'healers' within religious institutions maintained a striking continuity with the past and also resonates with the present. Risse cites St Benedict "...for these sick brethren let there be assigned a special room with an attendant who is God fearing, diligent and solicitous" (Benedict of Nursia, cited in Risse 1999, p100). Interestingly, Risse (the physician) calls the monk or nun carrying out these duties, the *infirmarius* - he does not use the English term 'nurse' or 'doctor' but prefers the Latin word, also notably evident today in the modern Spanish term for 'nurse' - *la enfermeria.*

Barbara Ehrenreich and Deidre English (1973) note an anti-empirical basis to the Church's approach to healing. They describe the thinking of the time as governed by the principle that "There was no point in looking for natural laws that govern physical phenomena, for the world is created anew by God in every instant" (p14). God could therefore give life and take it away and any role human beings might have in the healing of the sick was through appealing to the Deity. Risse also argues that the established Church maintained a great deal of control over the institutional care of the sick and that religious ritual was a major part of the experience of patients "...with sick inmates equated with Christ, caregivers considered the hospital as a substitute monastery where they performed their service to God" (1999, p153).

Theoretical and Practical Knowledge

Despite the anti-empirical stance of the Church, Risse notes that the *infirmarius* did require practical healing skills and moreover that their personality was also an important factor in their selection for the role. The knowledge and practical skill of the *infirmarius* was gained, according to Risse, from 'experience' and from "...consultation of texts, medical manuscripts and herbals available in the monastery's library or elsewhere" (p100). Risse's difficulty in assigning such 'modern' terminology as 'doctor' or 'nurse' to this role perhaps stems from the holistic nature of the work carried out. He notes the *infirmarius* not only ensured the sick were adequately clothed and fed, questioned and talked with, given comfort when required (tasks he described as *nursing functions)* but that they also diagnosed ailments and administered medicines, functions he described as *medical procedures.* Were these people nurses or physicians? Who 'owned' the knowledge required to carry out these functions? It appeared to matter little in the context of healing within a monastery in the 10th century. Indeed, the role and nature of theoretical and practical expertise of the *infirmarius* appear remarkably modern in form, particularly as the boundaries between medical and nursing knowledge which have been progressively erected to arguably

delineate and preserve professional power, are currently being questioned.

However, a division of (healing) labour on gendered, if not professional lines, was also becoming evident, here again in a monastery:

> The hospital's principle caregiving functions were executed by a group of primarily lay brothers, sisters and servants. By the twelfth century, a new division of labour had already assigned the physical care of the sick, as well as cooking and washing, to women. Men still did the heavy lifting chores but otherwise retreated to assume administrative and ceremonial responsibilities (Risse 1999, p152).

Another perspective on the division and ownership of healing knowledge is offered by Ehrenreich and English who write from both an American (where male domination of 'medicine' has always been more explicit than in Europe, the practice of midwifery for example remains illegal) and from a feminist position. They argue that:

> Women have always been healers. They were the unlicenced doctors and anatomists of western history. They were abortionists, nurses and counsellors. They were the pharmacists, cultivating healing herbs and exchanging the secrets of their uses..... They were called 'wise women' by the people, witches or charlatans by the authorities (1973, p3).

Indeed, although they argue that (female orientated) nursing became a mere adjunct to (male dominated) medicine and that healing was ultimately split on the basis of gender and therefore power, these authors also admit that "Healing, in its fullest sense, consists of both curing and caring, doctoring *and* nursing. The old lay healers of an earlier time had combined both functions, and were valued for both ..." (1973, p40). Ehrenreich and English trace the development of this divergence to the source and nature of the knowledge 'owned' by each group. As already noted, they argue the Church was 'deeply anti-empirical' "University-trained physicians were not permitted to practice without calling a priest to aid and advise them, or to treat a patient who refused confession" (1973 p16). Risse traces this rule to the Fourth Laterian Council of 1215 which restated the principle that corporeal illness stemmed from sinful

behaviour. Risse also suggests that in Europe during the Middle Ages, a shortage of what he terms 'trained medical professionals' (who he notes were extremely expensive to consult), encouraged "...the activities of monks who possessed medical knowledge. In addition, although officially barred from practising, a large group of empirics, Jews, Herbalists, barbers and midwives joined in caring for the bulk of the population" (1999, p153). Tellingly, this analysis of the nature of knowledge required by healers and barber-surgeons, who performed practical tasks such as bleeding, amputations and tooth extraction, illustrates that they had a much inferior status to university educated physicians and learned their trade through means of an apprenticeship.

Despite the gradual emergence of these male 'doctors', albeit practising under the constraints of the Church, Ehrenreich and English (1973) argue their knowledge base was anything but scientific. Rather, it was the result of studying the works of Galen, Plato and Aristotle and consisted of little more than superstition. They argue it was the (largely female) healers who had the greater understanding of anatomy and herbal pharmacology derived from years of empirical observation, but the siting of medical training in universities effectively excluded these women from practising legally. Indeed their success in 'curing and caring' was often used against them. Ehrenreich and English describe the case of Jacoba Felicie who was prosecuted by the Faculty of Medicine at the University of Paris in 1322 for practising outside the law. Her patients had often consulted university trained physicians prior to visiting her. It was alleged in court that:

> ...she would cure her patient of internal illness and wounds or of external abscesses. She would visit the sick assiduously and continue to examine the urine in the manner of physicians, feel the pulse, and touch the body and limbs.
>
> Six witnesses affirmed that Jacoba had cured them, even after numerous doctors had given up.....but these testimonials were used against her, for the charge was not that she was incompetent, but that – as a woman – she dared to cure at all (p18).

Those who continued to do so were often persecuted as witches, having effectively contravened the rules of both Church and the medical profession. The result, according to these feminist authors, was that women could take part in the "...healing process...*only* as nurses" (p3), and that "...the two functions were split irrevocably. Curing became the exclusive province of the doctor; caring was *relegated* to the nurse" [my italics] (1973, p40).

Summary

The practice of healing continued to be associated with, and influenced by, spiritual and religious values. The Christian ethos of actively encouraging its followers to help the sick and needy gave fresh impetus to the development of healing arts within a spiritual, vocational framework. Those who practised outside the authority of the established Church were increasingly marginalised and practitioners continued to take divergent paths dependent on the source of their knowledge, be it gained from a university or through an empirical, apprenticeship approach. Feminist writers argue that the empiricists included large numbers of women, who by the beginning of the 19th century were left with only one path to take if they wished to practice for monetary gain, that of 'nursing'. The evolution of nursing however, as will be seen, took place within a strongly Christian ethos, an ethos which guided Florence Nightingale's reforms and echoes of which can, I believe, still be heard at the beginning of the 21st century.

1.3 The development of 'modern' nursing during the nineteenth century – the influence of Florence Nightingale.

Ann Bradshaw notes that the historical responsibility of curing and caring shouldered by religious orders continued after the Reformation, albeit through the auspices of "Protestant philanthropy..." (2001a, p1). Bradshaw also describes the influence of religion on the development of nurse training in the nineteenth century and the

establishment of nursing 'orders' by both High Church and evangelical Christians and, in particular, illustrates that this influence is explicit in the reforms of Florence Nightingale. One of the most well known figures in nursing history, Nightingale is credited by Ehrenreich and English (1973) with having 'invented' nursing during the middle of the nineteenth century. They note that the inevitable effect of the gradual 'outlawing' of female healers was that 'nursing' became the residual female occupation:

> In the early 19th century, a "nurse" was simply a woman who happened to be nursing someone – a sick child or an aging relative. There were hospitals, and they did employ nurses. But the hospitals of the time served largely as refuges for the dying poor, with only token care provided (p35).

Ehrenreich and English argue that the context of the time made the nineteenth century ripe for nursing *reformers* such as Florence Nightingale and Elizabeth Fry. They note both Nightingale and her contemporary, Dorothea Dix, an American hospital reformer, were:

> ...refugees from the enforced leisure of Victorian ladyhood. Dix and Nightingale did not begin to carve out their reform careers until they were in their thirties, and faced with the prospect of a long, useless spinsterhood. They focused their energies on the care of the sick because this was a "natural" and acceptable interest of ladies of their class (p36).

The appalling conditions suffered by the injured in both the Crimean War and the American Civil War also gave these women ample opportunity to introduce their reforms into military hospitals. Nightingale expresses her thoughts on improving military hospitals and hospital nursing in this context, writing immediately after the Crimean War in 1858 in a supplement to a report requested from her by the then Secretary of State for War, Lord Panmure:

> This I propose doing, not by founding a Religious Order; but by training, systemising, and morally improving as far as may be permitted, that section of the large class of women supporting themselves by labour, who take to hospital-nursing for a livelihood, - by inducing, in the long run, some such women to contemplate usefulness, and the service of God, in the relief of man,

> as well as maintenance, and by incorporating with both these classes a certain proportion of gentlewomen who may think fit to adopt this occupation without pay, but under the same rules, and on the same strict footing of duty performed under definite superiors. These two latter elements, if efficient.... I would consider would elevate and leaven the mass (cited in Seymer 1954, p6).

Nightingale's emphasis on nursing being a paid occupation (except for a small minority of 'gentlewomen' who could support themselves through independent means) is important, as she distances herself from an alternative source of recruits, that of nuns and other members of religious orders. Whilst she acknowledged the long historical association of religious institutions with healing and caring for the sick, Nightingale was working within an era when secular institutions, whether military hospitals or institutions founded by Victorian philanthropy, were becoming established. She stated in her report that her priority was the aim of providing 'poor and virtuous women' with the means of earning a living, and regarded the introduction of particularly Roman Catholic Sisters into a secular institution as a possible source of "...confusion, of weakness, of disunion, and of mischief" (Nightingale 1858, cited in Seymer 1954, p7).

The care of the sick was, however, only 'natural' and 'acceptable' to the upper middle class ladies (Nightingale's 'gentlewomen') *after* it had been substantially reformed. Judith Godden (1997) describes the issue as a problem for Nightingale who needed "...to legitimize nursing as a paid occupation for middle class lay women" (p177). She sets the reforms in a context of an increasing need for not only Nightingale's 'poor virtuous women', but also a need for lower middle class single women to undertake paid employment. Nightingale attempted to address the problem by, as Godden argues "...utilizing images of the nurse, not as a paid worker, but as a quasi-religious, ladylike philanthropist" (p177). The relevance of this approach in the history of nurse education has been seen by some (Quinn and Prest 1987; Wake 1998) as resulting in an alleged greater weight given to the engendering of moral and spiritual knowledge

or vocation in Nightingale's reforms, in comparison to the gaining of theoretical or practical knowledge and skills.

Nightingale therefore had to reconcile a number of diverse objectives through a system of training and education which, as will be seen later in this thesis, is still in evidence. She had to provide niches for working class women who had always needed to work outside the home (but who in her view were otherwise at risk of having to accept employment of a less than virtuous nature), members of the middle classes who she regarded as 'valuable acquisitions to the work', and 'ladies' who she disparaged as lacking in "...Obedience, discipline, self control, work understood as work, hospital service as implying masters....and abnegation of self..." (Nightingale 1858, p8). She was not formulating a system of training for members of female religious orders who nevertheless possessed, as she noted "...undoubted advantages as to character, decorum, order....love and self sacrifice" (p6). As a result, she needed to 'invent' a moral and professional framework of training in which the advantages of the moral purpose of nuns could be instilled into 'ordinary' women who would also work for monetary gain. This had to be combined with the need for practical skills and theoretical knowledge of both secular institutions and (increasingly male-dominated) 'scientific' medicine. Nightingale also had to do this *outside* the traditional and protective environment of a religious institution *and* gain the approval and respect of all parties as a single woman reformer working in the middle of the nineteenth century. An account of the attempt to integrate moral and spiritual knowledge, scientific theory and practical skill into a coherent training programme for 'Nightingale Nurses' follows and I have again set this within the framework employed throughout this chapter - that of moral and spiritual knowledge and theoretical and practical knowledge.

Moral and Spiritual Knowledge

Bradshaw relates how, in 1851 and working at a Lutherian institution for the care of the sick in the German town of Kaiserwerth, Nightingale was able to make a comparison between a system of nursing founded on the notion that nursing work was carried out for altruistic motives and one being undertaken for mere monetary reasons. Nightingale describes the contemporary English scenario as a consequence of the latter motive where "We see the nurses drinking, we see the neglect at night owing to their falling asleep. Where women undertake so toilsome an office for hire and not for love, it cannot be otherwise" (Nightingale 1851, cited in Bradshaw 2001a, p3).

Although Nightingale was influenced by her experiences in Kaiserworth it is perhaps important to note that, for her, the moral foundation of nursing was more than that provided for by institutional religion, it was a vocation which involved "...responding to a moral demand of altruistic service" (Bradshaw 2001a, p9). However, it was a vocation which also had to accommodate the principle that nurses trained under the Nightingale system also had to be paid. Godden (1997) argues that:

> While Nightingale nurses had to be trained and paid, their motivation to undertake nursing was to be similar to that of a religiously inspired vocation. Nightingale won the right for middle class women to work in the public sphere but only by obscuring the essential nature of nursing as an occupation and a means of earning a living (p184).

Probationers (students) of the Nightingale School at St Thomas's Hospital, London during the 1860s needed to have a testimonial of character before their recruitment. To promote the moral purpose of nursing, probationers were required to 'live in' an attached nurses' home "...to fit them for moral life and discipline" (Wake 1998, p66). A home sister oversaw and took responsibility for the probationers' moral and spiritual training (Bradshaw 2001a). (I can also remember a Home Sister carrying out this remit during my nurse training in the early 1970s). Nightingale herself, when writing on

the subject of introducing female nurses into military and civil hospitals (1858, cited in Seymer 1954) stressed the importance of discipline during and after training, noting that caring for patients effectively was dependent "...on rule, system and superintendence" and if nurses could only be brought under God "...great things may be done..." (p14). I think there are interesting parallels here with Risse's earlier account of life in the Ascelepieion where a strict regimentation of dress and conduct was required along with the maintenance of routine and order to promote a sense of cohesion among patients (and perhaps therefore *security and peace*, in which healing was better facilitated). There are also many accounts of the 'moral' qualities advocated by Nightingale, including punctuality, orderliness, trustworthiness, cleanliness, cheerfulness, patience and quietness, qualities which were then, as now, necessary if good nursing care is to be achieved. Order was very important and probationers were taught to be punctual and efficient, to have everything ready before beginning any procedure or surgical dressing. All these characteristics, despite being brought under the remit of 'moral knowledge' also have a very obvious practical rationale, as they also did in the Ascelepieion or in St Benedict's monasteries. More specifically in a nineteenth century context and according to Bradshaw (2001a), Nightingale also believed that assigning a moral purpose to nursing work enabled women (perhaps particularly those from the middle classes) to undertake tasks (such as the disposal of patient excreta for example) which would normally have been left for servants. As part of their 'moral' training, nursing students were taught to have respect for authority, whether that was the ward sister, the hospital matron, or the medical staff. Ehrenreich and English (1973) interpret Nightingale's emphasis on obedience as demonstrating the subjugation of *female nurses* (for them, previously *healers*) to the rising status of scientific medical men:

> Nurses are taught not to question, not to challenge. "The doctor knows best." He is the shaman, in touch with the forbidden, mystically complex world of Science which we have been taught is beyond our grasp. Women health workers are alienated from the scientific substance of their work, restricted to the "womanly" business of nurturing and housekeeping... (p3).

Nightingale however regarded both the exercising of authority and the obeying of orders as again having a moral imperative, that of mutual co-operation for the benefit of patients. Respect for authority was linked with self respect (itself derived from a Christian 'calling') and an 'intelligent' obedience:

> Yet no *man* not even a doctor, ever gives any other definition of what a nurse should be than this – 'devoted and obedient.' This definition would do just as well for a porter. It might even do for a horse. It would not do for a policeman. Consider how many women there are who have nothing to devote – neither intelligence, nor eyes, nor ears, nor hands. They will sit up all night by the patient, it is true; but their attendance is worth nothing to him, nor their observations to the doctor...But let no woman suppose that obedience to the doctor is not absolutely necessary. Only, neither doctor nor nurse lay sufficient stress upon *intelligent* obedience, upon the fact that obedience *alone* is a very poor thing (1861, cited in Godden 1997, p172-173).

As part of their year long training, probationers in the Nightingale School at St Thomas's Hospital were given a lecture by the chaplain on a religious theme twice a week. When compared to the frequency (in 1873 in the same institution) of twenty two lectures delivered on a weekly basis by medical doctors throughout the year of training, some idea of the degree of emphasis given to moral knowledge can be gained.

Although probationers were assessed regularly on aspects of their character (truthfulness, sobriety and honesty), Nightingale never produced a detailed curriculum of moral and spiritual training. Rather, she set down her thoughts in a series of reports and addresses to probationers. For example, in 1872 she told probationers that the question of whether or not they were a Christian was the first and most important question they could ask themselves. By 1900, probationers were told they could honour or dishonour Christ as 'he is the author of our profession' through their nursing (Godden 1997). The emphasis on moral knowledge, and indeed purpose, grew as economic stringency and poor management led to worsening conditions for the probationers of the Nightingale School during the latter years of the 19th century. One

of the main causes of the financial problems facing the major London hospitals in particular was the agricultural depression of the 1870s. Many hospitals including St Thomas's depended largely on endowment income which was generated from farm rentals. Godden notes that by 1881 "...they (probationers) came to be taught, and were urged to accept their teaching with gentleness, patience, endurance [and] forbearance. There were to be limits on their learning; Nightingale urged the probationers to be good rather than clever nurses" (1997, p187). Despite Godden's implied cynicism surrounding Nightingale's insistence on vocation (and the overt cynicism of the feminist writers such as Barbara Ehrenreich and Deidre English), I would argue that much of Nightingale's promotion of moral knowledge and purpose enhanced rather than detracted from good practice. Anne Summers (1991) notes that Nightingale was a product of her time and that it is impossible to separate nursing history from the influence of Victorian Christianity and philanthropy. Indeed, the use of the terms 'vocation', 'moral and spiritual knowledge', and 'moral and spiritual knowledge and purpose' almost interchangeably throughout the remainder of this thesis is deliberate. On the one hand it is a recognition of the difficulty in a study of limited size to satisfactorily define and separate the terms, whilst it also acknowledges the importance of all these aspects of 'moral and spiritual knowledge' in the development of nursing and nursing education during and after Nightingale's reforms.

Theoretical and Practical Knowledge

Despite her apparent need to downplay the need for 'cleverness' in her probationers, as economic pressures impacted on her training school Nightingale's earlier stay at Kaiserwerth, whilst convincing her of the need for a moral basis to nursing, also led her to realise that possessing a vocation alone was insufficient to prepare a candidate to become an effective nurse - a nurse 'fit for purpose'.

A common theme running through 19th century narratives appears to be that of a recognition of the need for increased levels of knowledge, enabled through prescribed training and education, albeit underpinned by the *moral* foundation on which those newly learned skills and knowledge should be based. Breay (1897) links the terms 'ignorance' (of the early 19th century 'nurse') with 'dangerousness'. She notes the contribution of Elizabeth Fry who she claims to be the "...real pioneer of nursing in this country, (and who), recognised the necessity for providing more *skilled* [my italics] and trustworthy attendants for the sick of the richer classes" (p493). Breay claims Fry to be the chief moderniser of what she terms 'private' nursing - that which takes place in the patient's home - in contrast to the later hospital-based reforms of Nightingale. A 19th century medical perspective on the necessity of skilled nurses also notes "The physician at the bedside and the surgeon in the operating theatre had the conviction forced upon them that if they were to do the best for their patients, they wanted hands, gentle, *skilful* [my italics] and sympathetic, which would work with them and for them at the bedside" (Anon, British Medical Journal 1897, in Williams K 1980, p47).

Nightingale also believed that the moral basis of vocation could only be achieved through the application of knowledge, and an *intelligent* application at that. Nightingale did not necessarily regard the following of doctors' orders for example, or the carrying out of apparently 'menial' (in today's terms) tasks, as not requiring a knowledge base (Nightingale 1851). She also noted, linking knowledge and moral purpose again, that "We shall not work better for ignorance. [And – DC] Every increase in knowledge is a benefit, by shewing (sic) us more of the ways of God" (p6). Even more significantly in the pursuit of the all important linkage of theory and practice in contemporary nurse education, Nightingale claims that "...wisdom is the practical application of knowledge" (p6). For Nightingale then, the altruistic moral purpose of vocation was *enabled* by knowledge which itself became wisdom when applied to practice - the act of 'nursing' itself.

In the middle of the 19th century the separation of the concepts of 'theoretical knowledge' and 'practical knowledge', and the weight that should be put on each in the preparation of nurses, became a point of controversy. This was particularly so in relation to how far 'theoretical' knowledge should be regarded as a necessary component of nurse training, and indeed it remains so today. A medical historian writing in the British Medical Journal (Anon 1897) argued that:

> ...the theoretical side, (to nurse training) has been overdone; the style and method of training being on the same lines as those of the medical student, have not proved equally suitable to the sick nurse, whose work is essentially practical and whose efficiency depends more on *skilful handling and observation* [my italics] than on acquaintance with the minutiae of physiology or anatomy. A bad style of nurse has resulted from this false training and is on the increase (p1646).

Katherine Williams (1980), argues that what doctors meant by '*skilful handling*' were the outcomes of the training of a nursing workforce whose attributes consisted of "...a set of practices deriving mainly from medical knowledge" (p51), rather than being derived from a developing body of nursing knowledge based on Nightingale's principles. The accusation by a (male) doctor that the acquisition of knowledge of the workings of the human body produced a 'bad style of nurse' resonates well with Ehrenreich and English's (feminist) claim that the subservience of women health workers "*...*is reinforced by our ignorance, and our ignorance is *enforced"* (1973 p3).

However, for a nineteenth century nursing historian (Breay, 1897, cited in Williams 1980), the influence of the Nightingale model of training incorporating practical knowledge and theoretical knowledge underpinned by vocation had been shown to be necessary for the welfare of patients. In a remarkable parallel with contemporary opinion, Miss Breay argued that better educated nurses would benefit the profession generally but would, however, be more expensive to produce and would lead probationers to being regarded more as students and less as servants of their employers.

The Nightingale School at St Thomas's Hospital instituted a year long programme of both practical and theoretical education (Jebb 1861, cited in Seymer 1960). By 1873 the theoretical component comprised lectures on medicine and surgery, disinfection and artificial respiration. Lessons were given by medical doctors including a Mr Croft. In 1875 he published his lectures, together with a reading list and a text book, and also recommended Nightingale's own 'Notes on Nursing' to probationers (Seymer 1960). Practical knowledge and 'skills' were taught by the hospital ward sister on the ward itself and were considered to underpin the training course. The gaining of practical knowledge through working alongside the ward sister or other trained staff nurses is the origin of the term 'apprenticeship system' of nurse training, and Nightingale's ideas can be regarded as promoting the 'apprenticeship model', a model which was to last for at least another hundred years.

The ward sister was ultimately responsible for the practical instruction of the probationer, but often had to delegate this function to the staff nurses. In 1879 Mrs Wardroper, the first Matron of St Thomas's Hospital, wrote a syllabus of practical instruction and included not only the skills required to be learned but also offered advice as to how the teaching should be carried out. Written records kept by the sister detailed the experience of each student and included attendance records of lectures as well as progress gained in the managing of patients' hygiene needs, dressings, attending operations, bed making, management of helpless patients, application of leeches and other skills. They were to be taught the relevance of certain observations such as the different appearances of sputum, the first signs of bedsores and when to report these to the doctor. The sister, according to Mrs Wardroper, should show the probationer how to perform a task and also inform how it should *not* be done. She also advised that probationers should not be blamed for their ignorance, rather it was the duty of the sister to ensure they had been taught well. Probationers were to be taught *why* certain medicines were to be given, or specific dressings were used. They

were also encouraged to keep diaries of their learning and case reports and were examined by means of a written and oral examination, set and marked in the early years of the School by medical doctors (Seymer 1960).

Summary

Nurses in the Nightingale tradition were not only required to acquire theoretical and practical knowledge, they also needed to be subject to a third component to their training, that of the development of a vocation derived from a belief that nursing care required more that 'mere' theoretical or practical expertise. It required a form of altruism nurtured through a 'hidden', and sometimes not so hidden, curriculum of subjection to authority through the hierarchical structure of hospitals. It also entailed a humility generated and sustained through the insistence that even senior nurses and particularly those from the middle and upper classes could carry out the most 'distasteful' of tasks. Bradshaw (2001a) sums up the Nightingale era well, concluding "...they [nurses – DC] learned to be informed and practically competent; they acquired specific knowledge, skills and techniques through hospital training. Not just 'head' knowledge, it also involved the hands and the heart. No mere theory, this was a way of caring" (p23).

1.4 Nurse education policy at the beginning of the twentieth century

If the previous sections have perhaps concentrated on the roles of healers and early 'nurses' in addition to noting some tentative steps to regulating what, and how, a practitioner should learn, the debate at the end of the nineteenth century became increasingly about nurse education policy. A great deal of the literature debating the 'when', 'where' and 'how' of nurse education appears in official guidance and reports produced by both statutory and non statutory bodies. As the following narrative illustrates, many examples of pressure for change in the way nurses were prepared for practice appear to have been generated by the 'needs' of whatever form of Health

Service was in place at the time, rather than on any rationale generated by educational theory.

Celia Davies, a sociologist, argues that the Nightingale system of apprenticeship training did not represent a revolutionary new system of nurse training at all but actually meant that hospitals could staff themselves with a cheap labour force of well disciplined student nurses. As Davies puts it, "A system of nurse education conceived in this way (the apprenticeship model), made political and economic sense in the hospitals" (1980, p105).

The Nightingale system of training, with its three core values of theoretical, practical and moral instruction, gradually spread throughout the country during the latter half of the nineteenth century (Steele and Bristowe 1892). This publication reported on a survey undertaken to establish how nurses were being trained in different institutions. The results illustrated a wide range of approaches incorporating the Nightingale ethos. Courses ranged in length from one to three years; some examined theoretical knowledge while others did not. Hospitals were not the only institutions providing nurse training however, further diversity in training courses existed in community or home nursing training associations which utilised the voluntary hospitals for clinical experience; and there were also the workhouse nursing associations which subsidised nurses to train and then employed them in those workhouses (Davies 1980). The variety of training institutions and course content and structure eventually led to calls (Acland 1874; Rafferty 1996) for a standardised and controlled approach to nurse training, centred on the setting up of a register of trained nurses. Sir Henry Acland, Regius Professor of Medicine at Oxford first mooted the issue of registration in 1874.

The Influence of Moral and Spiritual Knowledge

Nightingale opposed registration and, in correspondence with Acland, argued that nursing was not like medicine which did require registration, as nursing had a moral basis to its foundation which could not be tested through an examination. She argued it was also not possible to register a training school as 'approved' on the grounds that the teaching staff held certain qualifications, as for Nightingale, it was the ward sister who should have the greatest influence on the training of students, particularly in respect of their moral qualities and their characters. Nightingale's insistence on the importance of the nurturing of moral character is illustrated by the following address to students:

> She may have gone through a first rate course – plenty of examinations. And we may find nothing inside. It may be the difference between a Nurse Nursing, and a Nurse reading a book on Nursing. Unless it bear fruit, it is all gilding and veneering; the reality is not there, growing, growing every year. Every Nurse must grow. No Nurse can stand still. She must go forward, or she will go backward, every year.
>
> And how can a Certificate or public Register show this! Rather, she ought to have a moral 'Clinical' Thermometer in herself (Nightingale, 1888 May 16).

The opposition to registration centred around the issue of measuring Nightingale's moral requirements of kindness, patience, trustworthiness and self control which were unquantifiable through conventional educational assessment techniques. William Rathbone was a Member of Parliament who also sat on the executive committee of the Nightingale School as well as that of the Liverpool Infirmary. He gave evidence to a House of Lords Select Committee (Second Report of the Select Committee 1891) to the effect that the better nurses were those who were judged by their matrons to be of good moral character and to be trustworthy and kind. They were not necessarily those who passed examinations, therefore how could a register be of benefit as it could not measure and therefore standardise a quality such as kindness?

Several Private Members' Bills setting out the legislation required to enable registration were introduced to Parliament but all failed to attract sufficient support and time to be fully considered. A Private Members Bill was again introduced and was finally passed in 1919 as the Nurses Registration Act. The General Nursing Council (GNC) was also established in the same year and was enabled by the Act to determine conditions for entry to, and maintain a register for, trained nurses. The Chairman of the Education and Examination Committee was Alicia Lloyd-Still, Matron of St Thomas's Hospital. Bradshaw (2001a) notes that Lloyd-Still's position at the original Nightingale School meant that the first national syllabus was firmly grounded in Nightingale's principles of theory, practice and vocation. Lloyd-Still's belief in the moral component of nursing was encapsulated in her statement to the 1921 committee "We realise that the finest, most fruitful work is done when the spirit of service is the energising force, and we would foster that spirit that we may not fall short of the great traditions of our predecessors" (Bradshaw 2001a, p85). Students would again have to be 'signed off' by the ward sister as both competent and of acceptable moral character in order to successfully complete their training. In order for an assessment to be made of the students' moral suitability and practical achievements, close supervision and monitoring was carried out on the wards.

Theoretical and Practical Knowledge

Despite the ultimate success of the campaign for registration, such was the earlier opposition that a petition had been sent to the Privy Council in 1892 by the Council of the Nightingale Fund against the Royal British Nurses Association (RBNA) (founded in 1887), being granted a charter allowing it to create a register of nurses (Steele and Bristow 1892). The argument against the Association was *inter alia,* that it would give the RBNA too much influence over the content and process of nurse education. Needless to say, the argument that Registration would somehow negate the effect of vocation was disputed by the RBNA. In particular the case was made by Dr Bedford

Fenwick (whose wife had founded the RBNA) to the effect that nurses needed technical knowledge in addition to vocation. He argued they needed to *understand* [my italics] patients' illnesses and symptoms in addition to knowing how to take temperatures and report abnormalities to the doctor. In order to test this knowledge and to standardise certification of competence, a centralised council for nursing should be formed which would impose uniformity of standards and hold a register of nurses meeting those standards. The question of the nurse's moral character could be settled through an assessment of such by the matron who would also certify the amount and nature of the experience gained by the student within her institution. Indeed, an excessive emphasis on vocation could, and did, lead to exploitation of nurses and to a shortage of applicants.

In general it was the doctors who emphasised the extending and standardising of technical and theoretical knowledge through regulation, and it was nurses who emphasised inclusion of moral qualities within its remit (Bradshaw 2001a). However, at a conference of hospital matrons and sister tutors it was also advocated that one national apprenticeship-based training be established which would acknowledge and address the need for a wider knowledge of anatomy and physiology, disease processes, social subjects and practical issues (Anon 1921). A further aim was to move some aspects of training out of institutions and into the community, thereby allowing nurses to gain knowledge and experience of public health work.

Summary

The arguments for and against registration of nurses appear therefore to have been centred on the relative emphasis given to Nightingale's three themes, those of moral and spiritual knowledge, theoretical knowledge and practical knowledge. The Nurses Registration Act 1919 made standardised training a legal requirement in England and Wales. The conditions for entry to the register were the completion of three years of

prescribed training and experience. The General Nursing Council (GNC) however was only given powers to prescribe an examination syllabus and not to organise, inspect or close schools deemed inadequate (Davies 1980). Discussions as to what the examination syllabus might comprise took place under the auspices of the Education and Examination Committee of the General Nursing Council.

1.5 1921 - 1948

Despite improvements in training, including the establishment of a national curriculum and the consensus that an apprenticeship training founded on theory, practice and moral and spiritual knowledge (vocation) was the optimal model, an apparent growing shortage of nurses was identified during the inter war years (Rafferty 1992). In 1930, the *Lancet* established a Commission to enquire into the problem and, whilst confirming its existence, noted that one of the most important causes was the relatively harsh conditions of service student nurses in particular had to endure. It argued that nursing compared unfavourably with new employment opportunities for women and that nursing shortages meant students had more routine ward work imposed on them, leaving less time for individual patient care and teaching opportunities (The Lancet Commission on Nursing 1932).

Moral and Spiritual

The Nightingale ideals of routine and order, discipline and hierarchy within which the moral basis of nursing was engendered appeared to conflict both with a growing desire of contemporary women for a more balanced life, and with advancing medical knowledge and methods the need for a more critical, analytical approach to nursing. The literature reveals that the emphasis on the vocational aspect of Nightingale's trinity begins to decrease as the 20th century progresses, at least in respect of its place in nurse training curricula. The moral 'purpose' of nursing was, and indeed is, unfortunately utilised by policy makers and some nurses themselves to 'justify' poor

working conditions, long working hours and low salaries. Judith Godden's citing of Elizabeth Glover's speech to the Royal Victorian Trained Nurses' Association is a case in point. Glover told her (Australian) Association that "We are professional women and work for the benefit of mankind not for twelve hours but for twenty four hours if the necessity arises" (1903, p11, cited in Godden 1997). Godden agrees with Baly (1986) who argues that Nightingale's motives in emphasising spiritual and moral knowledge and 'purpose' in order to create a profession acceptable to the Victorian middle class woman, gradually became "...ossified in an atmosphere of obedience and conformity. This ossification occurred as part of a worldwide trend. Later generations of Nightingale nurses and particularly nursing students, paid the price for retaining nineteenth century solutions well into the twentieth century" (1997, p177).

The suspicion that an overdependence on discipline and rigid rules was being used (wrongly) to justify the preservation of vocation by some in the nursing hierarchy was also reported by the Lancet Commission. The importance of vocation was however stressed in the Commission's report as an important safeguard against falling standards, standards which could not be maintained merely by paying nurses more, or indeed, increasing the resources available for nurse education. As will be seen, the debate in nurse education during this and later periods became not only one of the prominence to be given to vocation (this was largely reserved for questions on remuneration and conditions of employment) but also a question of the degree of theoretical knowledge to be taught in relation to that of practical knowledge and technical skills. This debate was driven largely by political and social changes brought about by the demands and demographic shifts caused by the Second World War and, subsequently, the setting up of the National Health Service.

Theoretical and Practical Knowledge

Unfortunately, instead of advocating an increase in resources for nurse education (vocation remaining as a 'safety net') in order to address growing recruitment and retention problems, the Lancet Commission's report advocated simplifying the examination syllabus and removing the more 'technical' aspects of theory on medicine, surgery and gynaecology. From a feminist perspective, as Ehrenreich and English have described it, this would seem to be 'enforcing ignorance'. "Women health workers are alienated from the scientific substance of their work, restricted to the 'womanly' business of nurturing and housekeeping – a passive silent majority" (1973, p3). Celia Davies (1980) argues that the Lancet Commission's Report was an inadequate analysis of the problem of attracting and keeping student nurses and also, unfortunately, one which influenced the recruitment and education policies which followed its publication, in particular the findings of the Interdepartmental Committee on Nursing Services (Ministry of Health Board of Education 1939, The Athlone Report). Both the Athlone Report and the Lancet Commission revealed (in their own surveys) the lack of resources made available to students in the inter-war years. Despite these findings, and although the Committee noted that conditions of service and pay should be improved, it said little about improving education, training opportunities and conditions in order to counter high failure and drop out rates. It may or may not have forgotten that Nightingale (as noted earlier) regarded knowledge as an *enabler* of vocation, not as *inimical* to it. In support of education, Davies also states that "...no one pushed the view that nursing *service* and nurse *education* were incompatible goals" [my italics] (1980, p112), an issue which has remained pertinent to the present day. She notes that in a sample of hospitals surveyed in 1930, students were expected to work a nine to ten hour shift and then attend lectures in their time off. (This system remained until at least the early nineteen seventies when I remember attending examination revision classes after working a twelve hour night shift as a student nurse). Davies argues cogently that Nightingale's 'compromise' of

'apprenticeship' training - students as employees - was economically advantageous to hospitals at the time but had not been challenged since the nineteenth century "...it became entrenched as the obvious and appropriate way of staffing the hospitals and training nurses. No one was able to challenge it, not even the nurses themselves" (1980, p117).

The Horder Committee's remit (Royal College of Nursing 1942, 1943 and 1949) was the implementation of the Athlone Report's recommendations. Horder was careful to tread a path between arguments (from doctors) that the theoretical component of nurse training was becoming too prominent - nurses needing only technical skill to carry out instructions from them, and from the other extreme - that nurse training should be modelled on that of teachers and take place in colleges of education.

Nursing, opined the committee, was essentially practical and, furthermore, the contribution to the hospital service made by student nurses would be lost if they became full time students in higher education. The 'problem' of who would staff the wards seemingly remained, and no doubt influenced the finding that nursing (in contrast presumably to surgery) appeared to be essentially a practical art. The Horder Committee nevertheless recommended that the nursing student should be primarily a student, and only secondly a worker (or apprentice). However, the apprenticeship system was not going to be discarded, it was to be seen rather as provider of practical experience to support the students' learning needs identified in study 'blocks' of theoretical instruction. The proposed introduction of 'blocks' of time in which lectures were taken in Schools of Nursing was an attempt to address the problem of students attending lectures in their own time after working long hours on the wards. While both the Athlone and Horder Reports agreed nursing was an essentially practical occupation, it was Horder who appreciated the additional need for 'theoretical knowledge' and for the need for more resources to be provided to facilitate learning.

White (1985) argues that one reason Horder was ignored at the time was due to the prevailing educational system of the post war period which catered principally for an elite, particularly in the arts and humanities. The concept of a level of 'knowledge' between practice and academia went unappreciated by most nurses, although Horder was aware of something Bradshaw (2001a) terms "...a growing technology" (p94), which was beginning to fill this space.

The issue of student status for student nurses arose again in 1946 when yet another committee convened to consider the problems associated with recruitment and retention of nurses. The imminent formation of the National Health Service had led to a forecast of a greatly increased demand for nurses and a new committee was charged with a comprehensive review of nurse training, an assessment of the role of the nurse, the social pool of potential recruits and reduction of 'wastage'. The committee was chaired by an academic, Sir Robert Wood, Chancellor of the University of Southampton and included a practising nurse, Miss E. Cockayne, Matron of the Royal Free Hospital, London.

Once again the committee noted problems associated with the apprenticeship system, finding that student nurses were students in name only as they spent most of their time performing routine tasks, some of which could be classed as non nursing duties for which no nursing training was actually required. The (Wood) Report also favoured an approach first mooted by the Great Conference on the Syllabus of Training and Affiliations Schemes (Anon, Making the Future Nurse 1921), that of a higher profile for health promotion and public health which would then be dovetailed with sick nursing. Wood wanted a complete modernisation of nursing and nurse education. He required a definition of nursing itself both in order to define the object of a revised education system, and linked with this aim, to ascertain what duties could be carried out by untrained 'helpers' or auxiliaries (Ministry of Health 1947).

Unsurprisingly, given the history of nurse training and the legacy of Nightingale's three principles of theory, practice and moral and spiritual knowledge, there was considerable opposition to Wood's proposals. The King Edward's Hospital Fund for London sent comments which blamed high wastage rates on irregular hours, an inadequate number of trained nurses, and the teaching of irrelevant theory (King Edward's Hospital Fund for London 1947). The Fund stated it would not support student status for nurses if it meant less time spent on the wards as this would lead to a less satisfactory standard of bedside nursing. The Royal College of Nursing (Royal College of Nursing 1948) supported the use of the term, 'student nurse status' rather than 'student status' to emphasise the unique position of the student as a hospital employee. The inference was that the hospital should retain control of this economically important member of staff. To bestow full student status would lead to *control of the students and the curriculum* being transferred to centres of education. (This was a battle which would be fought again in the 1980s and 1990s in relation to Project 2000 and its aftermath). The Royal College of Nursing (RCN) and the General Nursing Council (General Nursing Council 1948) both argued that the high wastage rates seen at that time were due to the influence of the recent war, during which unsuitable applicants had been accepted. It was agreed that nurses had needed to take on a greater proportion of work normally carried out by domestic staff, of which there was a shortage after the war. This again had led to high wastage rates and had little to do with the training system. Also, unconnected with the training system, was the issue of some students belatedly realising they had a general dislike of working with sick people - noted by the General Nursing Council (GNC) as another factor leading to students failing to complete their training.

This theme of blaming factors other than the training system was taken up by the British Hospitals Association (1948) which, like the RCN and the GNC, blamed the recent war for artificially distorting figures on student wastage rates. It also argued that

accusations of harsh discipline from senior staff were exaggerated, whilst admitting some improvements could be made in employment conditions. The Association also reiterated its support for the apprenticeship system "To acquire her arts and skills the student in nursing must be as much apprentice as she is student" (1948, p7). It also noted (in its capacity of employer of nurses) that a student nurse who visited a ward to observe and learn would inevitably cause disruption. The unresolved question of *who* (other than 'cheap' student labour) should staff the wards overshadowed all discussion.

Whilst Wood had criticised the repetitive nature of much practical experience, and even suggested reducing the training period from three to two years, the consensus of professional bodies and individuals who commented on the report appeared to be that repetition of practice was essential for learning (Bradshaw 2001a). Agreement also seemed to be founded on the need to reintroduce basic bedside nursing into nurse training. On this point I have found it impossible to find any evidence that it ever went away. However, parallels with contemporary arguments regarding the pre -eminence of 'bed side nursing' are inescapable - they are seemingly raised whenever any prospect of nurses gaining 'higher' educational qualifications arises. Ten leading (but anonymous) nurses (The Ten Group 1948) also submitted comments on the Wood Report, arguing for a definition of nursing, something the Wood Report had called for but not provided. They also called for an improvement in employment conditions for teachers qualified in modern educational theory, and even saw a place for graduate nurses. Dingwall et al (1988) note that the Wood Report had (with the benefit of hindsight):

> ...a remarkably modern flavour in their model of the division of labour. The nursing organisations seem almost Luddite in their opposition to a strengthening of the educational aspects of training and its constitution as the business of a separate organisation not dominated by service priorities (1988, p117).

And in relation to the defence of the three years training, as opposed to the reduction advocated by Wood:

> There is nothing magical about this particular time period: like any vocational training its length is dictated as much by custom and practice as by any coherent principle. More to the point may be the sort of attitudes picked out by the *Lancet* and Athlone investigations which treated nurse training as a mortifying experience during which girls were purified for their calling. The pointless repetition of mindless tasks as important to a system of discipline which could be used to identify and purge dissident elements. It was the weakening of this control which the leadership feared (1988, p118).

Summary

Perhaps inevitably with such vested interests involved, nurse training remained at the birth of the National Health Service, securely in the grip of the same apprenticeship system as existed when Nightingale founded St Thomas's Hospital School in 1861. Inroads had been made in improving the lot of the student nurse as a result of the introduction of protected study time for example recommended by the Horder Committee. In addition, the GNC could now impose higher standards on training schools and teachers of nurses as well as determining a syllabus for examination. However, nurses remained without the power to determine their own training system, or indeed their own definition of 'nursing' itself.

1.6 1949 – 1989

Revisions in the system of nurse training were minimal between the establishment of the National Health Service in 1948 and the Reporting of the Briggs Committee in 1972 (DHSS 1972). Revisions of the examination syllabus were undertaken by the General Nursing Council in 1952, 1962 and 1969. Nursing education continued to be undertaken in Schools of Nursing which were usually sited physically within a hospital campus. 'Training', as it was universally termed, took place both within the School and on the hospital wards. The integration of theory and practice, and cultural induction into the profession was facilitated by the close proximity of the two institutions.

Student nurses continued to form a large proportion of the hospital workforce on which the care of patients depended - they did not have supernumerary status. The General Nursing Council's syllabus of training which all Schools of Nursing were required to follow, noted in its preface that "Since nursing is essentially a practical art the majority of the training period will be spent in the wards and departments of the hospital learning and practising nursing skills under the guidance of Registered Nurses" (General Nursing Council 1969, p2).

Moral and Spiritual Knowledge

During the 1960s the importance of the vocational component of Nightingale's trinity of theory, and practice and vocation came under increased scrutiny. Bradshaw (2001a) believes the general ethos of change in society during that decade was the catalyst for change in nurse training. The Platt Report (Royal College of Nursing and National Council of Nurses of the United Kingdom 1964) commissioned by the Royal College of Nursing (RCN), considered that the apprenticeship system did not adequately address the need of students to understand a wider range of issues such as the psycho-social aspects of nursing. It argued that students should have genuine student status and be taught in colleges or universities. The idea of a 'professional' training was advocated - the *principles* of nursing could be taught in *higher education* whilst the *administering of patient care* was also considered essential and taught in clinical areas. Platt's recommendations appear to be very similar to those of Wood nearly 20 years earlier and indeed suffered criticism on similar lines, that of the supposed deleterious effects of any move away from the apprenticeship system of training. Bradshaw (2001a) notes however "Unlike previous reports, this had resulted in division in the profession about the nature of nursing. The RCN wanted to professionalise nursing by increasing its status and academic respectability, while the GNC wanted to preserve the service ethic" (p157). The battle between the two objectives, Bradshaw argues, was founded on the GNC's concerns about a loss of

influence in a training programme based away from the wards and, instead, sited in institutions of higher education. The GNC was at the time dominated by hospital matrons who were keen to emphasise the practical nature of nursing knowledge. Barbara Fawkes who was Chief Education Officer of the General Nursing Council from 1959 was unequivocal in her promotion of the development of positive, supportive attitudes such as 'cheerfulness' and 'sympathy' in patient care, and argued that the adoption of modern educational methods could foster these attributes. Bradshaw notes that Fawkes advocated the use of group work, project work and less formal 'lectures'. However, Fawkes believed that the moral characteristics of potential recruits was also important and they should form part of the process for selecting candidates for training. Bradshaw reports on the contribution of Eve Bendall, who was from 1969 the Chairman of the Examination and Education Committee of the GNC. Bendall went further than Fawkes in wanting more radical changes and based her views on her own research. Her study was undertaken at the London University Institute of Education and published in 1975. Bendall found that the students who expressed the greatest satisfaction with nursing were, in her words, the "most traditional", whereas those expressing dissatisfaction were likely to be more "analytical" and "radical". The traditional nurses were also more likely to hold the vocational aspect of nursing in higher esteem. Bendall argued "The 'overworked, underpaid 'angel of mercy', does not really exist in 1973 but the public like to think she does, and nurses do little to shatter the concept" (Bendall 1975, cited in Bradshaw 2001a, p220). Monica Pearce (Chairman of the Registration Committee of the GNC and also a hospital matron), writing from a service perspective, was however only too keen to perpetuate this image, and also that of nursing as a vocation:

> ....the nurse must remain true to her vocation (for such it is), seeing the sick person, in whatever area she meets him, as a human being, possessed of human rights, entitled to live a dignified life while it lasts, and entitled to die a dignified death when it comes. Wherever she may be, whatever she may do, one thing remains certain, she must continue to 'comfort always' (Pierce 1969, p152, cited in Bradshaw 2001a, p218).

I would hope no nurse would disagree with this view of the nursing role. Conflict appears to be centred on how to *engender* the qualities described by Pearce. Some, including Eve Bendall and Florence Nightingale as noted earlier, appear to regard education as enabling such moral and spiritual knowledge.

Theoretical and Practical Knowledge

A more general questioning of the practice of nursing, and the role of education in preparing nurses for that practice, resulted from two major pieces of research undertaken in the 1970s (Anderson 1973; Bendall 1976). In addition, numerous others including that of the DHSS (1972), the 'Briggs Report', argued for radical change in the educational process. These studies found that in general, and despite the pre-eminence of the apprenticeship system, students seemed to be poorly prepared for a role as a Registered Nurse and that the quality of their practical experience compounded this problem. They were found to have difficulties for example with linking 'theoretical knowledge' as learned in the classroom with their practical learning on the wards. The facilitators of this 'knowledge transfer' were assumed to be the ward sisters (Nightingale's ideal), helped by clinical teachers and visits from nurse tutors also from the Schools of Nursing. However, further studies (Burkey 1984; Reid 1985; Jacka & Lewin 1987) argued this assumption to be generally false in that over 66% of a student's time was spent either working alone or with unqualified staff or junior students, and only 11% was spent working alongside a qualified nurse.

The Briggs Committee found in favour of radical change in nurse education. Although the Committee was established in an era when social and academic pressure for change in general was high, Dingwall et al's (1988) analysis is that this particular change was precipitated by political and industrial strife and demands by nurses and other public sector workers which challenged the Labour Government's prices and incomes policy. Briggs was asked to look at giving nurses "...a completely new

standing and a new pay structure" (Crossman 1977, at 23.12.69 - diary date, no page number given). Its remit appeared to be an arguably impossible reconciliation of managerialism and professionalism "...to review the role of the nurse and the midwife in hospital and the community and the education and training required for that role, so that the best use is made of available manpower to meet present needs and the needs of an integrated health service" (DHSS 1972, p1).

Briggs recommended that Colleges of Nursing and Midwifery should be established, each with a governing body and financed by area committees. It advocated greater integration with social science disciplines and less with the medical profession. Education should pay more attention to research which would inform practice. In order to facilitate more research, recruits with higher educational qualifications should be sought. In summary this was a retreat from the Nightingale tradition and her preoccupation with 'vocation'. In order perhaps to cement this new 'professionalism' a single regulatory body was proposed and finally came to fruition as a result of the Nurses, Midwives and Health Visitors Act 1979. The Act enables the profession to devise its own education and training system within the legislative framework. It also enabled the establishment of the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (replacing the GNC) which became responsible for the registration and regulation of practitioners. For the first time nurses could regulate themselves and, in theory at least, decide how they wanted to be trained.

Summary

The role of theoretical knowledge, particularly that from the social sciences, was increasingly seen as a pre-requisite for the advancement of nursing as a *profession* and therefore as a means to attract more recruits. The Briggs Report advocated the siting of nurse education in institutions of higher education and the abolition of the 'apprenticeship' system of student nurses learning and working as hospital

employees. However, Bradshaw also reports on another view 'equally strong or stronger', prevalent amongst not only doctors who had their own protectionist reasons for fearing competition and indulging in the promotion of compliant nurse 'helpers', but also among nurses themselves which was "...profoundly anti intellectual, and held that nursing could only be learned by experience [arguing – DC] an inverse relationship between academic and practical ability" (Bradshaw 2001a, p221). This view, as will be seen in the following section, was to be repeated by doctors, journalists and members of the public as Briggs' recommendations were implemented.

1.7 'Project 2000' to the present day

Over a decade after Briggs, The Royal College of Nursing commissioned a study into the future of nurse education which also advocated that it be transferred to institutions of higher education and that student nurses should not form an integral part of the hospital workforce but should become supernumerary (Royal College of Nursing 1985). Part of the rationale was a desire to reduce 'wastage' of students in an employment market where there were increasing career options for the traditional young female recruits to nursing courses. Being part of the higher education sector was also seen as potentially more attractive to applicants. Additionally, it was thought that students educated to degree or diploma level would be less likely to leave the profession after qualifying, a conclusion supported by experimental small scale research projects carried out in a number of university departments and reported by Spouse (2003). So pressure for reform appeared to have two completely differing rationales, easier recruitment and retention of nurses and the addressing of the problems (see page 38 above), uncovered by Burkey (1984), Reid (1985) and Jacka and Lewin (1987), relating to the linking and application of knowledge learned by students in Schools of Nursing to their experiences in clinical practice.

Moral and Spiritual Knowledge

When I began to write this chapter I had assumed that the role of moral and spiritual knowledge in nursing and nurse education would have declined in a similar way during the latter half of the twentieth century, as perhaps has been perceived to be the case in society at large. In line with my assumption, Anne Bradshaw (2001b) reported on a survey commissioned and published by the Department of Health in 1998 which looked at attitudes to nursing amongst children and young people. She noted that according to researchers Foskett and Helmsley-Brown (1998):

> ...adolescents are naturally self obsessed, and the notion of caring for others more than themselves was unattractive. 'Helping' was considered a more active idea. Caring was considered to be passive, unassertive, feminine, involving the rather outdated notion of "self sacrifice" (cited in Bradshaw 2001b, p86).

Significantly, these findings were used to direct an advertising campaign aimed at increasing student nurse recruitment. Bradshaw notes that the researchers argued successfully that:

> The 'over-emphasis' on 'caring' should be readjusted to concentrate on 'helping' by presenting specialist areas, particularly children's nursing and midwifery. Images should be of intellectual knowledge required, teamworking and the avoidance of comparison with doctors. Nurses should be seen in an 'assertive advisory role', working at practical tasks that avoided injections or open wounds, and in 'practitioner' roles (2001b, p86).

The methodology used in this study was arguably problematic, a factor which may have some bearing on the apparent ineffectiveness of the campaign to significantly increase recruitment. The study used focus groups with the children which might be criticised, as Bradshaw does (and correctly in my view) on grounds of the possible distortion of participants' views as a result of peer pressure from within the group. What seemed to be important to these young people however, and also to those from another survey carried out by David Bullivant also published in 1998, was the issue of *status*, particularly in relation to that of doctors. The positioning of nurse education in

universities was ironically a double edged sword in respect of recruitment. Foskett and Helmsley-Brown's research found young people argued they might as well study medicine, rather than for a degree in nursing, as this would also give them increased *status* - status being more important to these young people than *caring.*

Bradshaw claims that "...The traditional caring role (in nursing) became less prestigious as basic caring values lost esteem in the late twentieth century, and practical care became synonymous with low status work" (p85). This of course was nothing new. Nightingale had to fight the same battle for status in the nineteenth century as noted earlier in this chapter. The remedy advocated by the proposers of Project 2000 for this perceived lack of status was to site nurse education in universities and, indeed, argue for an all graduate profession and the expansion of the nursing role into areas previously occupied by junior doctors.

Nightingale however, had stressed the importance of *moral and spiritual knowledge* in nursing work in her attempts to give nursing sufficient status to attract educated ladies of independent means and middle class women in need of paid employment. What needed to be asked of the new 'professionalisers' was whether standards of *basic* care [my italics] could be maintained simply by focussing nurse education on *theoretical and practical skills?* Could the influence of a moral and vocational element be ignored, or at least considerably downplayed? (I hesitate to use the word 'basic' in relation to *care* as it appears to suggest there is a level of care above and beyond that, or conversely, as is implied by some commentators, that nurses who carry out more advanced, technologically based work are not in some way offering care. The terminology is however used almost universally in the literature to describe *tasks* such as washing and feeding patients).

Commentators who expressed concern that somehow nurses did not seem to 'care' anymore, appeared however to find it difficult to separate this feeling of a loss of vocation from concerns about a lack of skill and knowledge. They could also be accused of failing to take into account effects of the concurrent shift from nurse management to that of generalist management by non-nurses as a result of the Griffiths Report (DHSS 1983) and the NHS and Community Care Act 1990. The subsequent implementation of clinical governance, accountability and a requirement for cost effectiveness, may or may not go some way to account for some of the complaints of a medical doctor, Mary Bliss, who alleged that nurses were focusing far too much on medico-legal issues, guidelines, and had even given up lifting patients so as to avoid back injuries. Nurses were too preoccupied by rehabilitation - one reason in her view why they were withdrawing from 'care'. She was also horrified to learn that bed making was now taught by ward staff and not the universities (Bliss 1998). Geoffrey Rivett, another doctor, accused "...academic nurses who...disparaged the earlier pattern of apprenticeship in hospital-based nursing schools, where the accent had been on clinical knowledge of disease and basic skills, hygiene and sterile technique, and in which safety and comfort of the patient were paramount" (1998, p446). He also concluded that there was a lack of clinical nurse management which might have helped the maintenance of standards of care, something which unfortunately was now completely outside the power of nurses to influence - medical and nursing protests against the NHS Bill during 1989 having had no effect on Parliament's intention to ratify the legislation.

These criticisms, of course, are from medical doctors and betray a lack of appreciation not only of the changing nature and purpose of nursing (as perceived by nurses themselves) but perhaps even more worryingly, a degree of ignorance of the contemporary legal and organisational issues which were consequences of the introduction of *managerialism* into the NHS. Their views also resonate with those of

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Ehrenreich and English (1973) - that ignorance in nurses was 'enforced' by the medical profession.

A perhaps more realistic view on the perceived problems in maintaining standards, was that expressed by a nurse in his maiden speech in the House of Lords. Hector Mackenzie noted that the public were being 'let down' by the programme of replacing registered nurses with health care assistants and other 'unqualified' staff. This, he claimed, was a result of the new managerialism which sought to introduce 'skill mix' into the nursing team in a response to the new supernumerary status of student nurses after Project 2000 was implemented. One problem with the health care assistants who largely replaced students was the lack of any standardised requirement for training and education, and an absence of any means to ensure personal accountability for practice (House of Lords 1999, cited in Bradshaw 2001b; Cockayne et al 2007).

There were therefore many changes impacting on nursing during this period, those of a revolutionary curriculum written by, and sited in, higher education institutions, perceived changes in societal values, and the growing impact of managerialism on working practices and, ultimately, education. Moral and spiritual knowledge - vocation, appeared to be under attack from those who wanted to emphasise nursing as a profession and for whom the 'angel' image was no longer tenable or desirable and who therefore welcomed the principles of Project 2000. Nursing was also under attack from those who favoured the 'helper' rather than 'carer' discourse identified by researchers Foskett and Hemsley-Brown and those (particularly general managers) who saw nursing as a series of 'tasks' which could be separated and allocated to differing grades of 'nurses' and nursing 'assistants' depending on how much technical skill or theoretical knowledge might be required to carry them out.

Nevertheless, the concept of vocation had not, contrary to my expectations, completely disappeared from nursing. A survey by *The Nursing Standard* published in 1997 revealed that nearly 65% of those nurses surveyed, thought nursing was a 'vocation'. Bradshaw (2001b), after reviewing several surveys carried out during the 1980s and 1990s, was able to conclude that "...grass roots nurses often still maintained traditional vocational values" (p112). But also, in her view:

> ....the sense of vocation which still motivated many people to become nurses meant that they did not want to relinquish the personal and caring aspects of their role. But the policy of the nursing leadership was to undermine this vocational ideal and its practical commitment, and to encourage nurses to develop and extend their roles away from *basic personal care*. The new system therefore worked against the sense of vocation which drew people into nursing in the first place [my italics] (p112).

Once again, the notion of 'basic personal care' has been elevated and given greater moral significance in relation to that of care given in other contexts. Given that the role of the qualified nurse *must* continue to expand as a consequence of medical and technological advances, this is a worrying assertion by Bradshaw, particularly if there is any remaining validity in Nightingale's argument that a moral basis to nursing work ensures high standards of care.

Theoretical and Practical Knowledge

The programme of moving nurse education into higher education institutions necessitated the costly replacement of student nurse 'labour' on the wards with more qualified nurses and health care assistants. The professional regulatory body, the United Kingdom Central Council (UKCC), had to agree on a compromise that 100% full time student status should be reduced to 80% for final year students (for economic rather than educational reasons). Even so, student contact with the clinical environment was reduced in comparison with the 'old' system, and registered nurses working in practice had to take more responsibility for student learning. Nurse lecturers were sited in universities and had much reduced contact with the clinical

area. Students graduated with a degree or diploma, and registered nurse status, but the issue of successfully integrating theory with practice did not appear to have been addressed. May (1997) found poor and inconsistent support of students in clinical areas. Indeed, although this chapter has been structured in terms of *moral and spiritual knowledge* and *theoretical knowledge and practical knowledge,* it was perhaps the discussions around the latter aspects which were given the greater emphasis during this period. The debate on the extent to which nurses need theoretical knowledge is of course nothing new and, as has been noted earlier, preoccupied Nightingale and her contemporaries. Christine Hancock, General Secretary of the Royal College of Nursing, argued in a speech to the RCN in February 1999 (Hancock 1999) that there was an unfair and unjustified campaign in the media against Project 2000 to the effect that nurses did not need academic qualifications on entry to training, nor did they need to be educated to degree or diploma level during that training. She quoted Brian Sewell, the then *London Evening Standard's* art critic as writing "....Nurses often achieve academic levels that far exceed those of many university courses – an appalling waste when applied to work at the bedpan level" (1999, p2), and journalist Minette Marin who wrote:

> Project 2000 has left us with...Intelligent nurses who squandered half their training in the classroom studying pseudo academic subjects such as race awareness, who arrive on the wards unable to take blood pressure or insert catheters (1999, p2).

In addition, there was the *Independent on Sunday* "...who in their editorial a few weeks ago, described Project 2000 as a sub-discipline of sub-Marxist sociology" (Hancock 1999, p2).

Hancock argued that the opposition to Project 2000 was founded on five 'myths', the first of which she described as a "...peculiar British prejudice against education which says you can't be educated and practical at the same time" (1999, p4). She noted

there was in fact much evidence that better educated nurses provided better quality care. The second 'myth' was that training had become too theoretical, whereas the ratio of practical and theoretical teaching time had only changed a little, from 60:40, to 50:50. She also argued against the third 'myth', that entry qualifications were at too high a level and stated her response that potential recruits were more likely to be deterred from nursing by low pay levels than higher academic entry requirements. Myth number four related to drop out rates, which were said to be higher under Project 2000. Hancock argued that in fact in the past "...there was a World War One attitude to training nurses – if you kept sending them 'over the top' then at least some of them would make it" (1999, p4). Finally, myth five related to Project 2000 education resulting in poor care for patients, with Hancock arguing that the traditional apprenticeship method of training actually taught nurses to perpetuate pointless rituals such as "...waking patients at 6am to change the beds" (p5).

The RCN is of course a professional body representing the interests of nurses, and thus can be expected to argue in favour of measures which it believes promote *their* interests (and, by inference, those of patients). Although the RCN supported Project 2000, unfortunately recruitment and retention fell after its introduction. Frank Dobson, then Secretary of State, blamed the nursing shortage on the increased *academic* component of education (which ironically only a few years previously had been promoted as a means to attract and retain students) as having dissuaded potential recruits from applying (Dobson 1999). He did so rather than perhaps considering the contribution of economic and demographic changes in the population of young women, the traditional source of student nurses.

An evaluation of Project 2000, the 'Peach Report' had been commissioned by the UKCC and was published in September 1999 (UKCC 1999). The report, 'Fitness for Practice', marked a greater emphasis on *practical* knowledge and skills, and a

'competency' approach to assessment. It also recommended longer student placements with agreed outcomes and support for students to be developed through agreements between university and health service staff, and between mentors and students. This support appears to have been articulated in the present system of staff nurse mentorship, audit and training of mentors by university lecturers and an administrative 'link' role with clinical areas in which lecturers are expected to 'trouble shoot' problems experienced by mentors and students with each other. It certainly does not include any form of teaching by university lecturers in the clinical area. Nevertheless, Sir Leonard Peach, the Commission's Chair stated that:

> By re-emphasising the value of practice based education within modern, university settings, and reorganising the nature of its delivery, the Commission believes it has struck the right balance. We were asked to focus on fitness for practice. If our recommendations are implemented quickly, patients and clients will get nurses and midwives who are better equipped at the point of registration to meet the immediate demands of the health services (1999 p3).

Arguably, the 'Peach Report' is another attempt to tinker with nurse training in order to reconcile managerialism, the needs of the service, with professional development. It should be emphasised again that under Project 2000, student nurses were no longer the employees of the Health Service and therefore rather than being members of the practice team, as they had been since Nightingale's reforms, became supernumerary to that team. This created a need to employ 'extra' staff to fill the gaps previously filled by inexpensive student labour. Importantly, Peach did not recommend a return to employee status and, indeed, Christine Hancock in her 1999 speech to the RCN Congress laid some of the blame for criticisms of the system and pressure for reform on shortages of qualified staff and resources in the NHS.

The Royal College of Nursing (Royal College of Nursing 2004), in a discussion paper on the future of nurse education, concurred with the Peach Report's positive restatement of the importance of practical skills. It argued that "Work based practice

learning will become increasingly important..." (p12) and envisaged both challenges and problems associated with the implications of 'Fitness for Practice' for nurse educators. These include the need to address integrating clinical practice with academia, and it (interestingly) reiterated that "The future nurse education workforce will not be based solely in higher education and their location will be as varied as future systems of delivering learning and educational support" (p12). It did not however make explicit how the integration of theory and practice would be successfully achieved and begged the question of how far we might be drifting back to the apprenticeship model. However, this time we are without the clinical teaching focus of the ward sister (Nightingale's linchpin of practical and vocational teaching) or 'ward manager' as they are now known, and which more accurately describes their remit.

1.8 Conclusion

This chapter has traced the development of some aspects of the role of 'healers' from classical times to the present. The analysis has been framed within three major 'types' of knowledge and the importance they have assumed over time. The theme of the importance accorded to spirituality and a moral basis to practice has pervaded both these historical and more recent accounts. Unfortunately, the history of nurse education has been shown to be one of continual attempts to reconcile the competing interests of politicians (as they attempt to meet the demands of their electorate), those institutions which employ nurses and which have to work within their financial budgets, those who work alongside them, for example medical doctors, and the aspirations of nurses themselves as they attempt to build and develop 'their' professional roles. As has also been noted in this chapter, these interests have also influenced and indeed driven the debate which has also been on-going at least from the inception of Nightingale's training school at St Thomas's Hospital. This debate involves discussion about what weight is to be given to the teaching of 'theoretical'

knowledge, 'practical' knowledge and skills and the development of 'moral and spiritual' knowledge - i.e. vocation intrinsic to nursing work.

More recently, after the implementation of Project 2000, responsibility for the content and process of nurse education was assumed by universities and this is where it lies at present. Criticisms of the type of nurse purportedly produced through this new system have been framed in terms of nurses being taught too much 'theoretical' and not enough 'practical' knowledge. Indeed, the Peach Report, as noted earlier, readjusted the ratio of this 'mix' of knowledge to a ration of 50:50 with the aim of producing a more satisfactory 'product', but did not challenge or analyse what these terms might mean - something which will be attempted in the following chapter of this thesis.

In addition, criticism of nursing education has also taken place in the context of profound changes in societal values - demographic changes which resulted in fewer potential recruits of the 'traditional' type (young, single and female), the expansion of alternative, well remunerated employment opportunities for this group, and not least, a profound change in the nature and governance of health care provision itself. In respect of the latter, Hancock's (1999) attack on the critics of Project 2000 set the criticisms in the context of changes in demands made of nurses, who now had to nurse critically ill patients on wards where, 20 years previously, those same patients would have been in an intensive care unit. She also noted faster patient turnover and technical advancements in nursing and medical treatments requiring an increased expertise - both practical and intellectual. The emphasis given by media critics to hospital nursing also betrays a misconception of the contemporary nursing role. For example, the use of the words 'bedside', 'basic care' and 'ward sister' are commonly used despite the greater numbers and significance of community nurses. In the present day and increasingly in the future, the typical patient seen by a nurse will have

walked into a health centre for advice or management of their chronic disease. The criticisms in the media, quoted by Hancock, perhaps reveal those purporting to speak on behalf of the public may not be aware of these changes and assume the image of the 'bedside' nurse dispensing bedpans is somehow typical of contemporary nursing practice. These images, along with the role of the nurse from the nurses' perspective, will be examined in chapter 3.

Chapter 2: The Nature of Nursing Knowledge

Introduction

In chapter one I introduced the concepts of theoretical knowledge, practical knowledge and moral and spiritual knowledge. The chapter traced the shifts in the relative importance afforded to each throughout the history of 'nursing' education. Inevitably perhaps in a piece of work which aims to address and describe patterns of emphasis and movement, the term 'knowledge' was left unexamined, other than in very general terms, each 'category' distinguishable and defined only in light of *where* and perhaps *how* it was gained. Contemporary nurse education, as has been seen, remains focused on the concept of 'integration' of theory and practice enhanced by a 'sprinkling' of ethical and moral teaching and purpose with 'proficiency' as the end product (Nursing and Midwifery Council 2004). Indeed, the Nursing and Midwifery Council (NMC) has no problem with using the terms 'theory' and 'practice' (in relation to pre registration syllabi) "The balance of learning shall be 50% practice and 50% theory..." (p17). The terms are defined by the NMC in line with European Directive 89/595/EEC which applies to all nurses undertaking pre-registration training as follows:

> (a) 'theoretical instruction' shall be defined as:
> That part of nursing training whereby student nurses acquire the knowledge, understanding and professional skills needed to plan, provide and assess total nursing care. This teaching is provided in nursing schools and other teaching environments chosen by the training institution and given by a staff of nursing teachers and other competent persons (Nursing and Midwifery Council 2004, p20).

Whereas:

> (b) 'clinical instruction' shall be defined as:
> That part of nursing training whereby student nurses as part of a team and in direct contact with a healthy or sick individual and/or a community learn to plan, provide and assess the required total nursing care on the basis of their acquired knowledge and skills. The student learns not only to be a member of the team, but to be a team leader organising total nursing care, including health education for individuals and small groups in the health institutions or the community (2004, p21).

A major question is raised by these definitions - is it tenable to distinguish 'types' of knowledge as the NMC has done and also in the way I have already taken for granted is the case throughout chapter 1? Self reflexively, my 'taken for granted' approach of analysing knowledge in terms of 'theoretical' and 'practical' knowledge arises both from my experience of training as a nurse in the 1970s and from my current experience of teaching student nurses using the same conceptual framework. It is interesting to note for example, that in the above definitions the NMC include within the remit of 'theoretical instruction', 'professional *skills*' [my italics]. It is debatable (as will be seen later in this chapter) whether professional *skills* can only, or even at all, be 'taught' formally as a series of theoretical propositions or whether they may also be acquired through working in the clinical environment alongside a qualified nurse. The ambiguous way terms such as 'knowledge' and 'skills' are used in these definitions can also be seen in the definition of 'clinical instruction' (above) where they both appear - presumably 'knowledge' in this sense is that of knowing *how*?

I intend in this chapter to critically analyse the distinctions between, in the first case, 'theoretical' (propositional) knowledge, secondly, 'practical' knowledge and finally, 'moral and spiritual' knowledge. Historical and contemporary nursing texts will be analysed in terms of the emphasis given to these knowledge 'forms' and an assessment of how far attitudes and approaches to their engendering have changed. This may help to shed light on some of the concerns expressed by nurses, the media and the public in respect of a perceived deterioration in nurses' practical knowledge and skills, and indeed, their sense of moral and spiritual purpose or vocation.

2.1 'Theoretical' knowledge

Steven Edwards argues cogently that the importance of being able to "...[place - DC] nursing practice on a basis of what is known [would seem to be - DC], preferable to basing nursing practice on what is merely believed or supposed" (2001, p21).

Evidence-based practice is central to modern health care, guided by bodies such as NICE (The National Institute of Clinical Excellence) which provides information on the appropriateness and cost effectiveness of treatments and care, at least in the National Health Service (NICE 2007). The NMC also requires registered nurses to practise 'proficiently' and in order to do so "... they must posses the knowledge, skills and abilities required for *lawful, safe and effective* practice...." [my italics] (Nursing and Midwifery Council 2004, p9). In addition, Edwards argues that the possession of a body of 'nursing' knowledge should enable 'nursing' to establish a unique identity in the professional sense.

He notes the influence of classical Greece, and in particular that of Plato, on Western philosophy and the assumption that all knowledge is attainable only through reason:

> Hence, a model of knowledge follows in which it is held that knowledge consists in the apprehension, by the faculty of reason, of truths. Moreover, these truths are held to be in propositional form. So a person knows that something *p* is the case by standing in a particular kind of mental relation to a proposition *p*. Thus all knowledge, it is held, is knowledge 'that', equivalently, propositional knowledge. (This is the case even for philosophers within the 'empiricist' tradition) (2001, p32).

Edwards applies this 'model' of knowledge to the action of giving an injection and proposes that the act (in fact any act) is composed of small steps, each of which "has an equivalent proposition" (p32) which must be followed to enable the act of injecting a patient with medication to take place, and which of course presupposes that theory precedes practice. "...Before being able to give an injection, one needs to learn and mentally 'store' the relevant series of instructions (for example, 1. Pick up the syringe, 2. Pick up the ampoule...and so on)" (p32). Edwards claims "What distinguishes the person who can perform the task (the expert), from one who cannot (the novice) is that the former has this internal manual and the latter has not" (p32). For this model, the same process (the acquiring of the 'internal manual') must be and is undertaken in my current employment in a School of Nursing in order to teach a student nurse to (for

example) move a helpless patient from their bed to a chair, or to insert a naso-gastric tube, or change an intravenous infusion. This takes place before the student is allowed to practise on a mannequin and later, a patient. Of course, human beings are not machines or computers and the concept of an 'internal manual', perhaps similar to a computer programme which students acquire and then operationalise in a standardised manner, is open to criticism in this context. Each student, as an individual, will arguably synthesise the theoretical 'propositions' in a slightly different way, producing different outcomes. Patients will react in differing ways depending on their physical and psychological condition. The experience of inserting a naso-gastric tube and experiencing the procedure from a patient's perspective will therefore differ between individual nurses and individual patients, creating difficulties for teachers in providing a set of 'theoretical propositions' which might meet all eventualities.

Continuing the examination of 'theoretical' knowledge, Joseph Dunne (2007), notes that:

> Already in Plato's day we find pretensions to professional expertise by practitioners in any field being checked against the status of the knowledge they could claim to possess; and Plato himself is committed to establishing the well groundedness of *techne* as a superior form of knowledge (p93).

The historical importance placed on the value of 'theoretical knowledge' has been illustrated in chapter 1 of this thesis, for example, Galen's advocating of 'aggressive questioning' to ascertain competence in healing practitioners (p5). The concept of a type of knowledge which goes beyond that needed to (merely?) *achieve* the goal of whatever craft or skill *(techne)* under consideration is well documented. For example, in Plato's dialogues 'knowledge' of the craft of carpentry is seen as essential to guiding the carpenter in using the right materials (Stanford 2003). However, Plato is also described as going further and arguing that:

> If one has a *techne* he knows how to do certain activities. For example the physician knows how to care for the sick, (Rep. 341e), to prescribe a regimen (Rep. 407d), to provide for the advantage of the body (Rep. 341e), to make someone healthy (Charm. 174c), to make someone vomit (Laws 933b). However the *episteme* (knowledge) associated with craft means more than simply knowing how to do certain activities. The physician knows or recognises health by medical knowledge. Since health is the goal of the medical craft, the physician knows the goal of the craft. Plato emphasises this knowledge as a distinct aspect of the craftsman's skill (Stanford 2003, p3).

The idea of being able to account for and justify one's actions to patients and peers seems to be important here. Questions such as why this particular treatment was prescribed rather than an alternative should be addressed for example. Or perhaps an explanation, no matter how inaccurate (judged from the standpoint of contemporary 21st century science), as to the mechanism by which a medicine heals a wound. "He (Socrates) says medical *techne* investigates the nature of things it cares for and the cause of what it does and has an account to give of each of them". (Gorgias (501a), cited in Stanford 2003, p3).

The historical rise of the university-educated male 'physician' and the relegation of the (largely female) 'healers', would seem to confirm that theoretical, propositional knowledge - 'knowing that' - being able to demonstrate an understanding and give an account of the goals of one's craft was also historically held in greater esteem than *only* knowing 'how'. For example, university trained physicians were deemed to possess a much higher status than barber surgeons who 'merely' carried out practical tasks such as amputations, something for which they required 'know how'. As has also been noted however, knowledge 'that' dispensed in universities in the Middle Ages until at least the beginning of the 20th century was considered to be of doubtful or little value and it could be argued that an ability to give an account of one's craft might have been found in the non-university trained 'healers' themselves - if anyone had looked - or, indeed, asked them.

Paul Standish (2007) argues that an occupation such as nursing which has only relatively recently become grounded in the universities must be under some pressure to "...assert its intellectual credentials..." (p109). Standish however, in stating that "...to educate a nurse is not merely to initiate them into a practice but to introduce them to the body of knowledge that informs that practice" (p109), does not appear to be advocating an unequivocal acceptance of the pre-eminence of propositional knowledge in the hierarchy of nurse education and the delineation of knowledge into merely 'that' and 'how'. Standish notes that the distinction is 'blurred' and cites Gilbert Ryle's (1949) 'intellectualist legend':

> Ryle was referring to the widely held and more or less Cartesian belief that a practically competent action must be preceded – at least logically, if not psychologically – by a mental operation, and his *The Concept of the Mind* was dedicated to the task of demonstrating and overcoming this false picture of mind, the idea of 'the ghost in the machine (Standish 2007, p109).

Ryle's argument is that the possession of propositional knowledge is not a necessary condition for being able to perform a practical task. In relation to my earlier example of student nurses being instructed in passing a naso-gastric tube or making a bed, the assumption currently is that they must be given, and have 'learned', a set of propositions in the university environment *before* being allowed to carry out the practical task in the clinical environment. Even in the clinical area however, the student is required to observe the procedure being carried out by a 'competent' qualified nurse before being allowed to practice the procedure under supervision. Gradually, after repeated experiences, the student will be deemed to have gained enough (theoretical, practical, or both?) knowledge to carry out the procedure alone. Where then does this leave the status and indeed value of the classroom teaching of the original set of propositions underpinning the practice of naso-gastric tube insertion? Is a classroom-based theory session therefore always necessary in order to give an account of one's goal and actions in inserting the tube before one has acquired the practical 'know how' to perform the task? Perhaps the context (including

how it is taught), the positionality and particular type of knowledge held by the individual teachers in the university environment may be contextually and indeed qualitatively different from that of teachers in the clinical environment?

It is clear from the above discussion and from issues relating to the emphasis placed on differing kinds of knowledge, and indeed on gender raised in chapter 1, that questions about the relative status afforded to propositional knowledge and practical 'know how' in the 'healing arts' have been shaped by societal structure, including that of a historical shifting of power between and from spiritual and religious institutions, the influence of scientific discoveries and the rise of industrialisation. Standish (2007) shows how Hubert Dreyfus traces the rise of a 'technical rationality' generated by the Industrial Revolution and its enduring relevance. Its aim is objectivity, measurability and explicability of operations or 'practice'. The rise of governance whether corporate or clinical, would seem to fulfil the demands of technical rationality in its promotion of transparent decision-making, operations and standardisation of procedure including that of (in the nursing context) clinical procedures and rationales for undertaking them. Having a rationale for practice, being able to 'account' for it and to develop standards and models to structure decision making surely requires the development of some form of 'theoretical' knowledge.

Barbara Carper's paper "Fundamental Patterns of Knowing in Nursing" (1978) also makes claims about the nature of knowledge specifically in relation to nursing - as she sees it. Carper identifies four patterns of knowing which she considers to be of value in nursing practice, those of a) empirics (the science of nursing); b) aesthetics (the art of nursing); c) the component of a personal knowledge in nursing; and d) ethics, the component of moral knowledge. Her first 'Pattern of Knowing', "Empirics: the science of nursing" (p14) is interpreted by Edwards (2001) as theoretical knowledge - knowing 'that', factual and descriptive, probably encompassing knowledge of the anatomy and

physiology of the body for example. But it appears from further reading that Carper sees 'empirics' as having a wider remit. "Thus the first fundamental pattern of knowing is empirical, factual, descriptive *and ultimately aimed at developing abstract and theoretical explanations* [my italics]. It is exemplary, discursively formulated and publicly verifiable" (1978, p15). Carper also describes what she perceives at the time of writing her paper as the 'science' of nursing at present as exhibiting:

> ...aspects of both the "natural history stage of inquiry" and the "stage of deductively formulated theory". The task of the natural history stage is primarily the description and classification of phenomena which are, generally speaking, ascertainable by direct observation and inspection (Northrop 1959). But current nursing literature clearly reflects a shift from this descriptive and classification form to increasingly theoretical analysis which is directed toward seeking, or inventing, explanations to account for observed and classified empirical facts. This shift is reflected in the change from a largely observational vocabulary whose terms have a distinct meaning and definition only in the context of the corresponding explanatory theory (1978, p15).

Perhaps a more contemporary description of Carper's 'publicly verifiable' pattern of knowing would be knowledge that is 'evidenced-based', although as Edwards points out (following Quine 1951), no 'fact' is immune from reappraisal and possible jettison. In Edwards' words, "These considerations show that Carper's empirical 'pattern of knowing' ought not to be taken to involve empirical knowledge. Rather, at least on one interpretation of what a 'pattern of knowing' is, it concerns beliefs about empirical matters" (2001, p43). Indeed, one of Edwards' major criticisms of Carper is that she does not articulate what she actually means by 'knowledge' (in contrast to 'belief'), inherent in her 'pattern of knowing', particularly as she also admits it is "...subject to change or revision" (Carper 1978 p22). Edwards' criticism of Carper's faith in evidence-based knowledge can be justified using the notion that a diet high in cholesterol predisposes people to heart disease. This was regarded as sufficiently 'factual' and based on empirical observations of the composition of fatty plaques adhering to the insides of coronary arteries. It was coupled with epidemiological 'evidence' that high rates of heart disease occur in populations who traditionally eat a

diet high in saturated fats such as cholesterol. Health education focussed on the perils of a diet high in cholesterol and the public was, and is, encouraged to have their cholesterol levels checked. More recently, these 'facts' have been reappraised as further 'evidence' has been gathered to suggest that there may be other factors involved in the development of heart disease, and that some types of cholesterol do in fact enhance health (BMJ 2002).

Patricia Benner (1984) also makes the distinction between practical knowledge and theoretical knowledge. Despite her emphasis on the attainment of 'expert' status in practice, largely through the gaining of practical knowledge and what she interprets as non empirically based sources of information, i.e. 'intuition', Benner also seems to believe that theoretical knowledge does have a place in the evolution of practice through the production of 'evidence' from research and in the necessary learning of the biological and social sciences. She also appears to site 'theoretical knowledge' in terms of, *inter alia* "abstract principles and formal models and theories" (1984, p193). One example she offers to illustrate this, is that of a student nurse in a clinical (practical) situation. The student, she argues, under the stimulus of an encounter with an anxious patient, will recall a lecture consisting of 'theoretical' knowledge (in her example, on communication skills) and will adapt his bodily positioning in relation to the patient in order to help allay the patient's anxiety. In her example, Benner was referring to the principle of postural echo, the student nurse initially 'echoing' the 'anxious' patient by leaning forward in his chair. Once the student recalled his lecture on the subject he could change his own posture to that of a more relaxed attitude - leaning back in his chair, thereby prompting the patient to do likewise. This example is offered by Benner as a small component of her overarching thesis on how 'novice' nurses become 'experts'.

However, like Gilbert Ryle, Benner does not appear to believe that theoretical or propositional knowledge is *always* required prior to being able to carry out a practical skill:

> Theory is a powerful tool for explaining and predicting. It shapes questions and allows the systematic examination of a series of events. Theorists try to identify the necessary and sufficient conditions for the occurrence of real situations. By establishing interactional causal relationships between events, scientists come to 'know that'. Philosophers of science such as Kuhn (1970) and Polanyi (1958), however, observe that 'knowing *that*' and 'knowing *how*' are two different kinds of knowledge. They point out that we have many skills (know how) that are acquired without 'knowing *that' and* further, that we cannot always theoretically account for our know-how for many common activities such as riding a bicycle or swimming (1984, p2).

Interestingly, by inference, Benner is also challenging what appears to be accepted as a 'given' in the design of nursing and medical curricula, that the teaching of theory will *inform* practice and *enable* the acquisition of practical skills demonstrated in the almost invariable siting of 'theoretical' instruction prior to the placing of students in clinical areas. As I have noted above, this sequence of events, 'knowing that' before attempting to 'know how', appears to be the accepted method of preparing nurses for practice, at least in my experience in the United Kingdom. In questioning this sequence of events Benner appears to go some way towards Barbara Carper's position that 'theory' seems to be increasingly directed towards *describing and explaining* observable phenomena - these phenomena perhaps including aspects of practice - know how? rather than, one presumes, *informing* practice? Interestingly, the Nursing and Midwifery Council (2004) also notes "Safe and effective practice requires a sound underpinning of the theoretical knowledge, which informs practice, *and is in turn informed by that practice"* [my italics] (p13). Theory could also be argued to be a powerful tool for confidence building, the possession of at least some propositional knowledge laying the foundations for practice, although there is also the argument that it may engender a false (and therefore in the nursing context, possibly dangerous) confidence in one's abilities to undertake a practical task.

2.2 'Practical Knowledge' (knowing how), Knowledge in the hands

'Practical knowledge' encompasses a broad spectrum of possibilities. It is therefore important to attempt to define and thence analyse what might be meant, particularly by the term 'practice'. For example, firstly, is possessing 'practical knowledge' merely being competent in 'performing a task' (perhaps possessing the 'skill' of giving an injection), or having the ability to judge whether a particular injection is required at a particular time? Or alternatively, is it a wider concept encompassing being an expert in the 'job' of nursing itself and including the achievement of qualities of excellence within that practice - its internal goods? Do these concepts actually only represent differing points on a continuum of knowledge (practical or otherwise?) as the model of skill acquisition posited by Dreyfus and Dreyfus (1980) would appear to suggest? This developmental theory describes the progression of a student from and through the stages of novice, advanced beginner, competent, proficient and expert.

Practical Knowledge – performing a task

The relationship between 'practical' and propositional or 'theoretical' knowledge is, as has been seen, somewhat problematical, Ryle (1949) arguing that not only does a distinction between the two exist but that theory does not necessarily precede practical knowledge, and even that practical knowledge may sometimes stand alone. So even when someone is able to describe the series of propositions required to carry out a practical task.... for example, the priming of an intravenous infusion giving set, this does not necessarily mean one is able to actually carry out the procedure safely. For example, *familiarity* or a degree of *dexterity* with the equipment somehow enables the filling of the tube without introducing potentially dangerous air bubbles and may be achieved without a 'theoretical' preparation. Indeed, Edwards (2001) notes in relation to Ryle's argument "At some point, since we manifestly do act and think, we must simply act without it being the case that our actions are prompted by consideration of an 'inner', mental proposition" (p33).

Martin Heidegger makes a similar point in relation to a division of knowledge and the ability of one 'type' to stand alone, with his concepts of the precedence of *things* 'ready-to-hand' (practical/implicit knowledge) over *things* 'present-at-hand' (theoretical/explicit knowledge) (Heidegger 1962). In his work *Being and Time* Heidegger illustrates his argument with the example of a carpenter using a hammer. When a carpenter wishes to hammer in a nail he reaches for his hammer without necessarily *thinking* about where it is or importantly, *how* to use it - in other words it is *ready-to-hand.* The knowledge of how to use the hammer is somehow embodied in the carpenter. This is a fundamental type of knowledge, and one dependent on the establishment of a relationship with an object as a useful piece of equipment which is utilised by someone for the purpose for which it was made. No theoretical considerations of how to use the hammer are required before and during the actual hammering. Heidegger argues that the theoretical component of knowledge in relation to the hammer example is only required if and when the hammer becomes lost or breaks. The hammer in this state becomes *present-at-hand,* and it is at this point that 'theoretical' knowledge of its mode of construction, and perhaps weight, balance and size, are needed in order for the carpenter to mend it, or indeed buy another one of equal or better utility.

Practical knowledge in this narrower sense of the possession of 'knowledge' enabling the performance of, or the carrying out of the 'practice' of, a task or skill such as priming an intravenous giving set or that of making a hospital bed (or hammering), has also been described in terms of 'bodily knowledge'. Edwards (2001) notes "...The fluidity of movement associated with expert performance of motor tasks is one of the features which helps distinguish the novice from the expert performer; the novice, it may be said, has yet to acquire bodily knowledge" (p34). In a similar manner to Heidegger, Merleau-Ponty (1962) describes this concept of 'bodily knowledge' as 'knowledge in the hands', and in doing so moves the debate even further away from

the Platonic view that all knowledge is propositional and derived from the reasoning of the *mind.* According to Merleau-Ponty, the learning and carrying out of practical tasks is not necessarily dependent on pre-existing (theoretical) knowledge and therefore the ability to mentally recount a series of propositions, which, once followed, will lead to the successful completion of the task. He also goes further and suggests that 'bodily knowledge' is not a series of individual steps which must be learned in order to carry out a complete task, i.e. in the case of priming a giving set mentioned above - 'remove giving set from sterile pack, close regulator valve, insert into intravenous fluid bag after removing cap from introducer, allow fluid to fill chamber before opening regulator and allowing fluid to fill all the tubing'. Rather, he states, the above steps are not independent of one another, nor indeed of the complete task. Thus, from the Merleau-Pontian perspective, the task is 'priming a giving set' and presumably may be learned as such and as a whole in order to achieve a seamless technique. As Edwards notes:

> So on the alternative, Merleau-Pontian view, the fluid movements of the musician, the footballer and the tennis player all manifest 'bodily' knowledge. And, with reference to the nursing context, the performance of complex motor tasks [for example giving injections again - DC] can also be seen as exemplifications of bodily knowledge (p34).

Therefore, the learning of a task is achieved through 'practice', the repetition of the movements required to complete a procedure quickly and successfully - 'success' being achieved when the task is completed. Edwards uses the term 'gearing in' in respect of the sequence of movements the body needs to learn in order to carry out the whole task or procedure. It requires the achievement of a degree of intentionality by the body which appears to be independent of the mind itself, i.e. it does not require the acting out of a series of mental propositions previously 'learned' perhaps from a text book or lecture. An obvious example here might be the advice given to learners of musical instruments to 'practice' through repetitively playing a particular piece until it can be played to the satisfaction of the player and teacher.

One objection to the concept of bodily knowledge centres on the type of tasks to which one might attach the term 'knowledge'. Hamlyn (1970) argues that it should be used for those which require some degree of skill. Therefore for Hamlyn, 'flexing one's muscles' cannot be classified as knowledge, bodily or otherwise, although as Edwards (2001) notes Merleau-Ponty would counter that learning how to make purposive movements, for example reaching out and grasping a toy, is a skill *learned* as a baby. However, the existence of reflexive movements in neonates such as the 'startle' reflex should be borne in mind. I would therefore counsel caution in describing 'learning' in relation to many motor skills without a much greater discussion on the input of genetic developmental impulses, all of which may contribute to the 'gearing in' of practical knowledge required to be able to crawl and then walk for example, but which are also outside the scope of this thesis. In addition, although the question of whether one needs to 'know that' in relation to both the priming of a giving set and learning how to play the piano, before 'knowing how' might remain unresolved in relation to these activities, it is perhaps important to point out that in relation to nursing, being able to account for the practical task to the patient and indeed to the NMC if required, must surely be essential. This also has important ramifications in relation to the requirement for assessing a student nurse's knowledge through the achievement of 'theoretical' as well as 'practical' outcomes as is currently the case, and as is likely to continue while ever knowledge is accepted as being divisible in such a manner. The division (and indeed assessment) of 'theoretical' and 'practical' knowledge is arguably difficult to defend if one can demonstrate (as Ryle seems to indicate is the case) 'proficiency' in one without a consideration of the other. This discussion is revisited in the final chapter of this thesis.

Practical Knowledge – a broader approach

Barbara Carper's second 'Fundamental Pattern of Knowing' (Carper 1978), as noted earlier, is that of 'aesthetics'. This she articulates as the art (rather than the 'science'

of empirics or theory) of nursing. She also appears (grudgingly) to bring it under the remit of 'knowing how', that is, 'practical knowledge':

> Here seems to be a self conscious reluctance to extend the term knowledge to include those aspects of knowing in nursing that are not the result of empirical investigation. There is, nonetheless, what might be described as a tacit admission that nursing is, at least in part, an art. Not much effort is made to elaborate or to make explicit this aesthetic pattern of knowing in nursing-other than to vaguely associate the "art" with the general category of manual and/or technical skills involved in nursing practice (p16).

For Carper however, the 'art' of nursing is more than the carrying out of (mere) practical tasks. She notes that "...[a – DC] 'fluid and open approach to the understanding and application of the concept of art and aesthetic meaning makes possible a wider consideration of conditions, situations and experiences in nursing ...including the creative process of discovery in the empirical pattern of knowing" (p16). She draws on ideas of the 'expressive' (rather than 'descriptive') nature of art (Rader 1960), something which may result in "...the creation and/or appreciation of a singular, particular, subjective expression of imagined possibilities or equivalent realities..." (p16). Unfortunately for technical rationalists, these expressions of possibilities are not amenable to testing, nor are they generalisable as was the knowledge explicit in her first pattern of knowing, that of empirics, or the science of nursing. Carper appears to be claiming here that the nursing needs of a particular patient who, for example, has undergone the removal of his appendix will (or *may*?) differ from another patient undergoing the same procedure. This is perhaps easy to accept given that patients are individuals who may differ markedly physiologically and in emotional and social terms. Other authors (Roper, et al 1996, Hilton 2005) have made similar claims to the effect that every patient should be treated as an individual and receive care tailored to their particular needs. Where Carper appears to break new ground is to use the term 'aesthetics' to describe the design and delivery of nursing care. She argues for the primacy of 'perception' over 'recognition' when applied to patient needs for example. The recognition of the needs of a patient having

undergone surgery is currently normally driven by a more managerialist system characterised by, for example, the 'tick box' approach of pre-printed care plans which instruct the nurse to take the patient's blood pressure every half an hour for the first two hours post operatively and then reduce it to hourly - and so on. The nurse in the managerialist scenario is arguably transformed into a technician, 'operating' both the patient and blood pressure measuring equipment. In contrast, Carper argues:

> Perception, however, goes beyond recognition in that it includes an active gathering together of details and scattered particulars into an experienced whole for the purpose of seeing what is there. It is perception rather than mere recognition that results in a unity of ends and means which give the action taken an aesthetic quality (p17).

Carper also cites 'empathy' as an important constituent making up the 'art' of nursing and argues that "The more skilled the nurse becomes in perceiving and empathising with the lives of others, the more knowledge or understanding will be gained of alternate modes of perceiving reality" (p17). This ability will then enable the nurse to 'design' (Carper's word) a plan of care for the patient which, presumably, will be in some way 'better' (Carper uses the words "effective" and "satisfying") than the usual 'scientific' care plan which should be based on current evidence. Edwards (2001) criticises Carper on the issue of her use of artistic terminology to describe nursing actions under this head. He questions her use of the term 'aesthetics' in that it, as he notes, is normally applied to artistic artefacts such as paintings, sculpture or perhaps music. He argues "For what matters in nursing is whether a nurse nurses properly and this need not amount to behaving 'beautifully' or even 'gracefully'" (p44). Carper's use of the word 'effective' is also problematic here. If, as Carper herself states, aesthetics cannot be described and analysed in any objective, scientific way, then how may the results (in terms of care given) of an experienced nurse 'perceiving and empathising' be described as 'effective'? Edwards suggests that this could possibly be achieved by comparing the outcomes of similar situations handled by different nurses, and offers

the example of one nurse being more skilful than another in dealing with 'dangerously aggressive' patients, i.e. one nurse (perhaps the one skilled in the 'art' of nursing) manages to achieve or meet the 'ends' of nursing, perhaps calming the patient, in contrast to the other, less aesthetically skilled, who does not. Edwards again criticises Carper's use of the word 'aesthetics' stating:

> She seems to conflate the ideas of art and skilled performance of a craft. From the fact that works of art necessarily have aesthetic properties, she concludes erroneously that skilled performance of nursing actions similarly must posses such properties. It is suggested here that such properties are at most contingent, accidental features of nursing actions. As suggested above, surely what matters most is whether or not nursing acts meet the ends of nursing? (2001, p45).

I wonder however, whether Edwards is considering the use of 'aesthetics' and 'art' in a rather narrow sense, that of a consideration of the art of painting or dance. Carper argues for a wider definition, for a more "...fluid and open approach to the understanding and application of the concept of art and aesthetic meaning...[which – DC]...makes possible a wider consideration of conditions, situations and experiences in nursing" (p16). Carper's call for nurses to perceive the particular rather than the general and design their care accordingly in an aesthetically pleasing (for the patient) manner surely cannot be criticised too heavily, except perhaps on grounds of achievability in a target driven Health Service. Ultimately, for the purpose of this section, one factor of major importance is that of the question of how and where this 'pattern of knowing' may be categorised. It has already been noted earlier that Carper appears to confirm its practical basis. The powers of observation required to be developed to discern 'the particular' can only be gained from clinical practice itself.

Patricia Benner (1984), as has been noted earlier in this chapter, also accepts a distinction between theoretical or propositional knowledge and practical knowledge. Nevertheless, she does not accept that the prior acquisition of propositional knowledge is a necessary condition for the acquiring of practical knowledge. She

gives the example of the palpation of a contracted uterus to illustrate her argument i.e. that an assessment of whether a uterus is normally contracted or otherwise can only be learned through practice and the acquisition of practical knowledge. Arguably, the same could be said for the 'feel' of a vein into which an intravenous infusion is being run. A contraction of the vein is often the cause of the infusion failing to run properly, causing leakage around the entrance site and pain for the patient. On the other hand, the cannula may no longer be in the vein and infusion fluid may be leaking into the tissues around the site. Both scenarios can very often be diagnosed by 'feeling' along the vein and judging its tonicity and the degree of swelling around the site itself. The ability to do this through the possession of such 'practical' knowledge is important, as the remedies for a vein in spasm and a vein no longer cannulated are very different. A decision that a uterus either possesses a degree of 'hardness' and is therefore normally contracted (rather than being too soft and therefore liable to result in a possible haemorrhage) will set in train a series of events which could either result in a patient's death or complete recovery. The need for some degree of 'theoretical' knowledge to enable the nurse to account for what she or he has 'felt' and to justify the actions taken is evident. The question is once again however, whether that knowledge needs to inform the decision, account for it, or both.

I also include in this 'wider' interpretation of practical knowledge Dunne's (2007) discussion on the need for 'judgement'. He argues that "Judgement is more than the possession of general knowledge just because it is the ability to actuate this knowledge with relevance, appropriateness, or sensitivity to context" (p97). Again, this is not practical knowledge in the 'narrow' sense, an ability to carry out a particular skilled operation such as taking a blood sample (venepuncture) which can be shown to a student repeatedly until they feel confident to try the procedure themselves under supervision and then carry it out alone. Judgement, in Dunne's view, is the sum of the knowledge acquired through past experiences of carrying out venepuncture with that

encountered in each new patient which informs the action to be taken in respect of that patient presently sitting in front of the nurse. For example, a patient who has no visible veins into which a needle can be inserted will require a different application of practical knowledge such as warming the limb or tapping the skin above a vein to encourage its appearance. The practitioner will also need (from past experience) to be able to *judge* when such a technique may or may not be successful and when to utilise more invasive techniques or even to abandon the attempt altogether until the patient is more adequately prepared. However, as Dunne also notes, *judgement* is not an inevitable product of experience and "...It is of course possible to have experiences from which we do not learn: it is a commonplace observation, for example, that the thirty years 'experience' of some practitioners reduces to one year's experience, repeated stalely thereafter" (p97).

It would perhaps be inappropriate to apply the concepts of 'bodily intention' and 'bodily knowledge', as proposed by Merleau-Ponty (1962), to this broader interpretation of practical knowledge. Terms such as Dunne's *judgement,* Carper's *aesthetic patterns of knowing,* and Benner's *intuition* discussed in the next section, would also appear to defy categorisation in this way.

Practical Knowledge – intuition?

Benner (1984) describes how 'expert' nurses may experience 'gut feelings' about a patient who they believe is about to deteriorate despite perhaps their blood pressure, pulse or temperature appearing to be normal. Edwards (2001) asks two questions in relation to Benner's concept of 'intuition'. Is she describing "...a kind of mystical ability to foretell the future, if imprecisely, to the effect that 'something' is wrong with the patient, or less vaguely, 'that the patient is about to erupt in temper'?" (p52). Or, is she accepting that "...intuitive judgements are prompted by (presumably) empirically available information?" (p53). He notes that Benner appears to try to have it both

ways "...seeming to deny that such expert judgements need be based upon 'explicit signals' " (p52), but also "...explicitly rejecting the assimilation of intuition with any kind of mystical power" (p52). Benner in fact states in her glossary that "...intuitive grasp ...should not be confused with mysticism" (1984, p295), and seems on balance to accept that intuitive knowledge is the ability to recognise and see a pattern in a host of cues through viewing a patient holistically. She notes that:

> Capturing the descriptions of expert performance is difficult because the expert operates from a deep understanding of the total situation; the chess master, for instance, when asked why he or she made a particularly masterful move, will just say: "Because it felt right". "It looked good" (1984, p32).

Michael Luntley (2007) looks at the relationships between intuitive knowledge and 'knowing how'. He uses the following scenario to illustrate his argument:

> A nurse in an intensive care unit (ITU) has charge of the care of a patient who is recovering after major surgery. The patient has a feeding tube and is unable to communicate verbally with the nurse. In addition, given the level of sedation, the patient has limited opportunity for communicating their needs in any other way. The protocol in ITU is for feeding tubes in cases like these to be removed six days after surgery. By the third day, the nurse has a growing concern that the patient is uncomfortable with the tube. By the fourth day, the nurse's concern is so strong that she takes the decision to remove the tube. She has no articulate account of why she thought this was the right action. The most she can say is that she had a 'feeling', an 'intuitive sense' that this would greatly enhance the patient's comfort. After removal of the tube the nurse is proven right and as the patient recovers, they thank the nurse for removing the tube at that time (p77).

Only an 'expert' nurse, Luntley notes, would possess this type of knowledge which he terms 'experiential'. His major argument here is that the nurse in question cannot 'account' for what she did "All she has is an inarticulate sense that what she did was called for or was appropriate in that situation" (2007 p78). Luntley also claims this type of knowledge would be termed 'intuitive' by Benner and would be characteristic of the nurses at the 'expert' end of Benner's (1984) 'novice to expert' trajectory, or as Luntley terms it, 'inarticulate expert'.

Benner's (1984) description of this trajectory of learning is, as she states, based on Dreyfus and Dreyfus' (1980) model of skill acquisition which she applies to nursing. She begins with a description of the novice nurse who relies on rule governed practice which has been informed in the main by 'theory', and progresses through the stage of advanced beginner "...those who have coped with enough real situations to note...the recurring meaningful situational components that are termed 'aspects of the situation' in the Dreyfus model" (p22). The third stage is that of the competent nurse who can plan her work in order to establish a perspective and avoid stimulus-driven responses to managing care. In the next stage, the proficient nurse does not plan the perspective but " [it – DC]...'presents itself' based upon experience and recent events" (p27). Finally, the expert nurse "...now has an intuitive grasp of each situation and zeroes in on the accurate region of the problem without wasteful consideration of a large range of unfruitful, alternative diagnoses and solutions" (p32). One issue in relation to Benner's description of the 'expert' is that of his or her ability to somehow know what the 'accurate region of the problem' might be. The idea that someone might feel it 'wasteful' to consider other alternatives is worrying and more than hints at a rigidity of thought and resistance to innovation. The behaviour of the expert in this respect seems none too far from the 'rule governed practice' demonstrated by the novice. One difference might be that, in the case of the novice, the rules are imposed externally in the form of a conceptual framework or a protocol of treatment, perhaps both learned in the classroom. The expert however is relying mainly on an internal, self generated manual of knowledge based on previous experiences – one product of which *may* be 'intuition'.

An ability to note (perceive or recognise?) 'the particular' in relation to an individual patient, resonates with Barbara Carper's (1978) account of her 'aesthetic' pattern of knowing, described earlier. Is intuition also about 'perception', as Carper would have it? In any event, Luntley's argument is that we need to understand what is happening

when nurses display the 'intuitive knowledge' he calls a 'pattern of recognition' in order to be able to extend the trajectory of knowing from 'inarticulate' expert to 'articulate' expert. He notes that the question is an important one and needs to be addressed, particularly in relation to experiential or 'practical knowledge' and the apparent differing levels of awareness and capacities inherent within the concept itself. Otherwise, as he says "...training would be passive...a matter of practice, like bike riding". The instruction "...'Let's go care for the patient' would in this case, be the only direction needed to the novice nurse who would eventually 'catch on'." (p82).

My observation on Luntley's scenario of the nurse who was unable to articulate *why* she removed the feeding tube on the fourth day rather than on the sixth, is that her supposed inability to explain why she thought the patient was uncomfortable has been taken as self evident and unchallenged. It is unclear from Luntley's text whether the scenario is factual. It is not impossible however to assume that in a real situation, questioning and probing the nurse about her observations of the patient would have revealed her noticing minor aspects of behaviours when the tube was disturbed. She may have noticed for example, discomfort or pain, perhaps evidenced by eye movements - given he was sedated. If this is the case then this type of 'knowledge' is not something which *cannot* be articulated – it does not perhaps have a 'mystical' element to it, but rather it is a manifestation of an inability to articulate something which nevertheless could *be* articulated.

2.3 Moral and spiritual knowledge

The third and final major aspect of knowledge to be examined in this chapter is that of moral and spiritual knowledge. Its importance has been acknowledged in chapter 1 of this thesis where its influence has been described as being particularly strong in periods of history when empirical, scientific knowledge of physiology was lacking. Healing took place largely in religious institutions and religious ritual was deemed an

integral part of the healing process itself (Risse 1999). The purpose of moral and spiritual knowledge in healing and ultimately in respect of this thesis, nursing, appears to be two-fold. Firstly, and particularly in the classical world (Risse 1999), knowledge of religion and religious practices would seem to be required, as healers may have been priests or members of religious orders. Secondly, the influence of Christianity further strengthened the link between spiritual and moral purpose and care for the sick and, as has been described above, did so even when scientific advances in understanding of disease processes were taking place during the later nineteenth and early twentieth centuries. Christianity, notes Risse, actively promotes helping the sick as integral to maintaining a personal relationship with God and hence it was thought that healers should exhibit behaviours reflecting this relationship.

The concept of spiritual and moral *purpose* and its concomitant requirement for engendering a body of enabling knowledge and behaviours was recognised by Florence Nightingale (her strategies for developing this aspect of nursing knowledge have been described earlier). However, in the context of the discussion about the nature of knowledge undertaken in this chapter, I believe it is important to widen the remit of the objectives of moral and spiritual knowledge as a means to commit to the good of the public, profession and institutions, to include other fields of work. John Drummond in his Ph.D thesis, *A Call to Training* (1998) argues that the moral training provided by the Nightingale School should be set in the context of nineteenth century reforms of *inter alia* the police service and changing attitudes to the management of domestic servants and factory workers. Some of the examples of moral education he offers have remarkable similarities to the ideas and reforms of Nightingale as discussed above, but were applied to male workers too:

> Beginning with the police themselves, ...attempts to discipline "motley rascals" into an efficient police force included lodging the constables in dormitories adjacent to the station-house and prohibiting them from fraternising in public houses or penny theatres....uniforms were introduced.... Separation of

> domestic servants from general working class life was a form of isolationism for a more efficient surveillance and moral training which included the installation of "habits of personal cleanliness and neatness, punctuality, obedience, good manners and general discipline."...In mining districts, both employers and clergy were incited to take on the role of 'moral guide' during the workers' leisure hours....so they can be trained in 'the virtues most valuable to the labouring man - honesty, prudence, forethought, temperance, frugality'...(p202).

Drummond uses the term 'virtuous bodies' to describe the nurses who were the end products of the inculcation of moral qualities which took place within nurses' homes and wards. It was the possession of a body of knowledge with a moral and spiritual purpose underpinning it which Nightingale believed promoted the learning of both theoretical and practical knowledge and which was, therefore, for the 'good' of the profession and the patient and incidentally provided uncomplaining labour for hospitals.

Alasdair MacIntyre (1981) offers a wider view of 'practical knowledge' which appears to embrace the notion of the need for 'something else', stating:

> By a 'practice' I am going to mean any coherent and complex form of socially established cooperative human activity through which goods internal to that form of activity are realised in the course of trying to achieve those standards of excellence which are appropriate to, and partially definitive of, that form of activity, with the result that human powers to achieve excellence, and human conceptions of the ends and goods involved, are systematically extended (p175).

MacIntyre's concept of 'internal goods', according to Joseph Dunne (2007), may include the aimed-for outcomes of the practice, health - in the case of nursing practice, and also for Plato's 'goals' of medical 'craft', which are *in excess* of the minimum required for their achievement. Dunne contrasts the internal goods of a practice with external goods of (for example) monetary reward. He does this also in relation to other practitioners (those engaged in the same practice) and notes that characteristics such as competitiveness do not (or perhaps, *should not*) occur when practitioners are working in tandem in pursuit of the internal goods of that activity as

"...every achievement of excellence potentially enriches all who participate in or care about a practice" (2007 p92). The striving for excellence, in respect of outcomes of good health and the concomitant need for cooperation and teamwork to achieve these goods internal to nursing practice, would seem to constitute a strong relationship to perhaps 'vocation' - some moral and spiritual purpose and knowledge. The inference to be drawn from MacIntyre's and Dunne's articulations of the desirability of acquiring the ability to create these 'internal goods' of practice would seem to be that they can (only?) be achieved through working in and experiencing clinical work - MacIntyre in the quote above uses the words "in the course of trying to achieve", which on one interpretation would seem to indicate a course of action in the practical field.

However, Dunne argues that it may not be possible to utilise 'practical knowledge' alone in the pursuit of achieving the internal goods of practice:

> ...rather than treating it as a means for achieving external goods (for example, money or status, which are external in that they could be achieved by some other means) – unless one has also acquired virtues such as patience, temperance, courage or honesty. Together, these qualities direct one's energy and attention as well as disciplining one's desires (2007 p92).

Anne Scott (2006) also argues that concepts of goodness and badness permeate the practice of nursing in terms of considerations of:

> What is good and bad, for the human, what will hurt, distress, and comfort the patient as a human being. What is good and bad, harmful or comfort-giving is normally seen to be part of the moral sphere of operation. In other words, a focus on human needs and what is good or bad for patients assumes insight into and an understanding of what is reasonably termed morally relevant elements of nursing practice (p138).

This, a much more *holistic approach* to practice, will be discussed further in Chapter 4 of this thesis in relation to a consideration of a more inclusive concept of moral and spiritual knowledge.

Meanwhile, and in relation to the striving for the internal goods of practice, Anne Begley notes that "Within the context of Greek ethics, virtue (arete) is a word used to describe excellence in quality...Anything good performs its function well and demonstrates virtue, arete, or excellence" (2006, p258).

Aristotle

The notion that there is something perhaps above and beyond the rigid categorising of knowledge into 'theory', 'practice' and 'moral and ethical knowledge' can also be found in Aristotle's writings. This 'something else' has already been articulated by Dunne and MacIntyre (above) as the internal goods of practice and the pursuit of excellence, and also in Scott's articulation of the concepts of 'goodness' and 'badness' in nursing. Aristotle writes of something arguably similar (but not the same), that of *phronesis.* He describes it as an awareness of justice, of what is the right thing to do "...to know what is just and what is unjust requires men think, no great wisdom...but how actions must be done...in order to be just, to know *this* is a greater achievement than knowing what is good for the health..." (E.N.9.1137a9-17, cited in Dunne 1993, p272). In addition, Dunne argues that not only is *phronesis* not *merely* a body or category of *formulated* knowledge (the distinction is an important one) but that "...phronesis falls on the side of virtue rather than of knowledge" (1993, p273). It is not a 'cognitive capacity' which can presumably be learned in the way one may be taught how to process information and to interact with others through cognitive behavioural therapy "...but is rather, very closely bound up with the kind of person that one is" (p273).

Aristotle contrasts *phronesis* with *techne* in the sense that a form of knowledge such as *techne* or even *episteme* can, he argues, be forgotten by those in which these 'categories' of knowledge reside. 'Theory' and 'practical knowledge' may be applied or not to a situation in hand, depending on the will of the possessor. They may even be

applied for good or ill, as Dunne puts it "...a person who possesses the *techne* of medicine, for instance, is capable of bringing about not just health but also illness; his techne, as such, can be deployed in either direction at his behest" (Dunne 1993, p264). In other words, in the case of *techne,* one has control over the exercise of one's knowledge. A mistake will either demonstrate a lack of, or an imperfection in that knowledge if involuntary, or if deliberate it will illustrate a choice has been made to withhold one's expertise in that particular circumstance. Aristotle puts it thus "...while there is excellence in *techne*, there is no such thing as excellence in *phronesis*; and in *techne* he who errs willingly is preferable, but in *phronesis*, as in the [ethical] excellences, he is the reverse" (E.N 1140b21-24, cited in Dunne 1993, p264). So it may be possible, if not always desirable, for one to exercise one's discretion to withhold medical treatment for reasons which may or may not appear reasonable to others, or to speak abruptly and inappropriately to a patient despite knowing this was unjustified by reference to any given circumstances, or even to do so in ignorance. However, Aristotle appears to be saying on this interpretation, that in the case of *phronesis*, using one's discretion to act in a negative way is even less desirable. The reason according to Dunne is, as has already been noted, because one's *phronesis* is closely bound to the identity of that individual self:

> In relation to one's *phronesis*, one has no discretionary powers to be exercised by some superordinate self. Here one is fully engaged, and whatever mistakes one makes must be put down to oneself; they cannot be ascribed to one's lack of skill (as in the case of involuntary mistakes in *techne*) or to some covert intention of one's own which makes one master of the mistake (as in voluntary mistakes in *techne*) (Dunne 1993, p266).

Gadamer (1975) draws the distinction between *techne* and *phronesis* in terms of a moral or ethical component to consciousness (*phronesis*) and an ability to create an object (*techne*). He argues that because a man cannot 'dispose' of himself, his 'moral consciousness' in *the same way* [my italics] he shapes or creates an object from a base material, these terms (*phronesis* and *techne*) therefore define two different types

of knowledge. It is arguable however that one may in fact be able to shape one's own consciousness through self examination, experience of exposure to virtuous, 'good' behaviour and the development of a degree of self reflexivity. Jim Mackenzie (1991) also finds fault with Gadamer's conclusion noting that, particularly in the dramatic arts, actors need to utilise the concept of "*...the self as instrument...*" [as – DC] "The master performer must have complete control of his *instrument,* and that of an artist is a complex mechanism...[being – DC] obliged to play simultaneously on all the spiritual and physical aspects of a human being" (Stanislavski 1950, p294, cited in Mackenzie 1991, p159). The implication of Mackenzie's argument is that the distinction between *techne* and *phronesis* has not been well made by Gadamer. Both 'make' something, the potter a pot and the actor himself into some-*one* or, as I would argue, some-*thing* else. I state some-'thing' else as I do not believe acting is perhaps the best example Mackenzie could have utilised, the actor is surely not changing his self 'the kind of person he is' rather he is playing *the part* of another 'self'. I would argue that both are demonstrating *techne,* the actor is able to use discretion on whether to put on an exemplary performance or not, the potter whether to make a decent pot, despite their both having the 'knowledge' to do so.

Mackenzie (1991) analyses Wilfred Carr's (1987) distinction between *inter alia, techne* and *phronesis.* Carr observes that *techne* is a form of knowledge which guides action which brings about an end product – this form of action he terms *poiesis.* This end product must be known beforehand and the knowledge needed to achieve it must therefore be a form of technical 'know-how' which will necessarily rely on a certain degree of rule following. In contrast, 'practice' or *praxis* is guided by *phronesis* and:

> ...the end of a practice is not to produce an object or artefact, but to realise some morally worthwhile 'good'. But, secondly, practice is not a neutral instrument by means of which this 'good' can be produced. The 'good' for the sake of which a practice is pursued cannot be 'made', it can only be 'done'. 'Practice' is a form of 'doing action' precisely because its end can only be

> realised 'through' action and can only exist in the action itself (Carr 1987, p169).

Carr appears to say that the ends of 'practice' (guided as it is by *phronesis*) cannot be determined in advance, rather "Practice is thus what we would call morally informed or morally committed action...Another way in which practice differs from *poiesis* is that its ends are neither immutable nor fixed. Instead, they are constantly revised as the 'goods' intrinsic to practice are progressively pursued" (1987, p169). So at the point where it might be assumed the concept of *phronesis* would assist in ascertaining to what extent nursing work can be categorised as being guided by the concept, the work of nurses appears (on this analysis) to be guided rather by *techne,* as at least one major goal of nursing is that of enabling recovery from illness, an end which appears unambiguous and unamenable to revision. However, all may not be lost in that the history of healing described in chapter 1 of this thesis would seem to indicate that at least the first two of Carr's descriptions of 'practice' can be identified closely with nursing work (and thus, suggesting the influence of *phronesis* in guiding it), particularly in relation to Nightingale's insistence on altruistic service and a sense of vocation. In other words, the goals (or ends) of nursing are not only health (leading it towards *poiesis*) but there is also another component to nursing concerned with process (or means) - the importance of nursing *well.* This is particularly pertinent in relation to nursing and also teaching, as it would seem the means should influence for good or ill, the ability to attain the ends (wellness or an educated mind) of these activities.

Aristotle argued that physicians *do* deliberate about means rather than ends. For him the ends of medicine are clear, those of curing the sick. It is *how best* to achieve this end which is the subject of deliberation by the practitioner (Eth.Nic. iii3, 1112b12ff, cited in Mackenzie (1991), p160). How then does the influence of *phronesis* best help this process (or should it, as by 'best' do we mean morally or ethically 'best' or

perhaps 'best' as the result closest to a predetermined measure of success?) particularly, as for Aristotle, medicine falls within *poiesis* and is thus guided by *techne*? Dunne (1993) also notes that Aristotle had difficulty in reconciling this dilemma and in therefore defining the "...precise type of knowledge that informs us about 'how actions are to be done'" (p272). Can therefore *phronesis* be appropriated to help clarify what it is that nurses need to *be* in order to nurse well, to know *how it feels,* to be *kind* or the much arguably overused term *caring*?

Carr (1987) attempts to develop the concept of deliberation on ends and means through the introduction in his text of the terms 'technical' and 'practical' reasoning:

> The overall purpose of technical reasoning is to consider the relative effectiveness of action as a means to some end...Practical reasoning is not a method for determining *how* to do something, but for deciding what *ought* to be done (p171).

Practical reasoning or 'judgement' is a term and concept explored by Dunne (2007) at page 67 (above), and by Richard Smith (1999) who prefers the term 'judgement' to 'reasoning' on the basis that "...'practical reasoning' risks being taken as suggesting a technical, almost algorithmic process..." (p209). Dunne (1993) links *phronesis* to *judgement* thus:

> Phronesis is committed to a pursuit of the good, a good, moreover, which is rooted in a definite ethos with its own favoured dispositions and habits. Still, this good cannot be determined in advance of the actual situations in which it is to be realised. And so *phronesis*, as the kind of knowledge that makes one sensitive to it, is characterised at least as much by a perceptiveness with regard to concrete particulars as by a knowledge of universal principles (p273).

Therefore, rather than being a 'category' of knowledge in the manner of 'theory' or 'practice', *phronesis* according to Dunne "...is not a knowledge of ethical ideas as such, but rather a resourcefulness of mind that is called into play and responds uniquely to the situation in which these ideas are to be realised" (1993, p272). In

addition, as Smith argues, "The attentiveness in practical judgement means that one is constantly open to further experience and the possibility of modifying one's judgement" (1999, p209).

So what is the role of *phronesis* in practical judgement particularly in nursing? Is a 'phronetic' model of nursing required? As Smith notes, practical judgement always involves an ethical component. This is because unlike the mechanistic nature of technical reason, it allows and indeed requires the exercise of discretion and the manner in which it is carried out reflects the character of the person in question. For example the practical judgement exercised by Michael Luntley's intensive care nurse on page 69 of this thesis could be argued to have arisen in her greater concern for the comfort of her patient than in any apprehension over disciplinary action consequent on her removing her patient's feeding tube before that period of time specified in the regulations.

MacIntyre's concept of acting 'virtuously' would seem to have much in common with *phronesis* as he appears to assume that exercising the virtues is not performed in order to achieve a particular goal, it is performed because *it is the right thing to do.* As MacIntyre puts it:

> Virtues are dispositions not only to act in particular ways, but also to feel in particular ways. To act virtuously is not, as Kant was later to think, to act against inclination; it is to act from inclination formed by the cultivation of the virtues. Moral education is an 'education sentimentale' (1981, p140).

It is however the identification of *phronesis* which I find most exciting in terms of nursing education in that it may provide a way of identifying and perhaps describing what a 'good' nurse might be, what they need to *possess* - one who might be described as 'caring' as well as being able to demonstrate *technical reasoning.* If the importance of a *virtuous character* cannot be recognised, then inevitably it will not be

engendered in nurse education either in the university or in clinical situations. For example, how might the hypothetical Chair of the meeting in Richard Smith's (1999) example have learned the behaviour he describes?

> It [practical judgement – DC] is never simply a matter of what 'skills' she is exercising or what rules she is following. In chairing a meeting, for example, she encourages one colleague to hold the floor but another to be brief. Now she attempts a summary of where the meeting has got to, but now she allows ideas to go backwards and forwards in a relatively chaotic way. At one point she lightens the atmosphere with a joke, at another reminds colleagues of inexorable external pressures. The things she does more or less instinctively, and they flow to a large extent from the sort of person she is: generous and good-humoured, or tense, defensive and impatient. Later her colleagues are as likely to remark on her character as on her technical ability to chair meetings (1999, p209).

Finally, Paul Standish (2007), in a remarkably perceptive piece of writing, implies that the theoretical and practical aspects of nursing knowledge do not, and indeed should not, comprise the totality of what is required to be a nurse:

> Nursing inevitably involves more than technical competence then, but one might go further and say that the implications of this for nursing are more far-reaching than for doctors themselves. The nurse is the one who stays when nothing more can be done (p123).

The foregoing begs the question therefore of what kind of moral and spiritual 'knowledge' a nurse requires in effect to work within *phronesis,* to establish a personal relationship with his or her God, to maintain a 'virtuous body', and ultimately to "stay when nothing more can be done"? Further discussion on the place and the promotion of moral and spiritual knowledge in nursing education will be undertaken in chapter 4.

2.4 The Nature of Knowledge – Key Nursing Texts

The following texts span a period of time of nearly 150 years and have been analysed in order to investigate the nature of the knowledge about nursing the respective authors have attempted to promote. The first text is one of Florence Nightingale's original writings illustrating her views on the role of the nurse. It is part of a selection of

her works collated by Seymer and has been chosen specifically for the purposes of this thesis as she sets out her views on the minutiae of day to day care of the sick. Other publications by Nightingale in Seymer's volume deal with the setting up and organisation of hospitals and the staffing of such, and I have deemed them of less relevance to this thesis. The texts by Powell (1968) and Hector (1973) have been chosen as they were the recommended books of my own nurse training course undertaken in 1972. As such, they underpinned and formed a great deal of my own, my fellow students', teachers' and ward sisters' attitudes and thinking about nursing both at the time, and arguably, also in our subsequent careers. The book edited by Hilton (2005) has been chosen as a contemporary text used extensively by students currently undertaking their pre-registration training and therefore can justifiably be considered to influence the thinking and reflect the practice of present day and future newly qualified nurses.

(i) Seymer (1954) Selected Writings of Florence Nightingale: Notes on Nursing: What It Is and What It Is Not (1859)

Lucy Seymer's collection of Nightingale's original writings span a period of time from 1858 to1894 and therefore reflect Nightingale's thoughts on nursing before and after the Nightingale School was opened in 1860. Seymer notes in relation to the whole collection of writings that it is not a 'textbook' in, as she puts it "...the modern meaning of the term, to guide both her student nurses and their teachers..." (p.viii). Indeed it is remarkable that in comparison with later writers of nursing texts, there is little or no descriptive narrative regarding (theoretical) knowledge as a series of instructions regarding how to perform, for example, the bandaging of an amputee's stump, or the dressing of a wound (see p.52, above). Neither is information presented in tabular form with aims, objectives and rationales of particular nursing procedures. Rather, Nightingale writes in a narrative manner and the work has the look and feel of a novel rather than a 'scientific, evidenced-based' text book on nursing.

Detailed knowledge of microbiology and the transmission of infection were imperfectly understood in the middle of the nineteenth century, however, Nightingale's grasp of the importance of environmental health is impressive and surprisingly 'modern'. A major part of the theoretical knowledge dispensed by Nightingale appears to be the prevention of disease through the procuring of a healthy living and working environment. In this, she was not averse to criticising architects for their poorly designed houses which had drains running beneath them, were too dark, or could not be adequately ventilated. Similarly, in the hospital setting, Nightingale extols the virtues of ventilation and is not afraid to challenge some of the received wisdom of the day:

> Another extraordinary fallacy is the dread of night air. What air can be breathed at night but night air? The choice is between pure night air from without and foul night air from within. Most people prefer the latter. An unaccountable choice. What will they say if it is proved to be true that fully one-half of all the disease we suffer from is occasioned by people sleeping with their windows shut? (Nightingale 1859, cited in Seymer 1954, p130).

There is little mention of anatomy and physiology as a separate subject of study; such issues were to be left, as has been noted earlier in this thesis, to the lectures by medical doctors in the Nightingale School. However, Nightingale appears to have a good knowledge of the subject which she dispenses in applied form in relation as here, to patients who may be hypothermic:

> A careful nurse will keep a constant watch over her sick, especially weak, protracted and collapsed cases, to guard against the effects of the loss of vital heat by the patient himself. In certain diseased states much less heat is produced than in health....The feet and legs should be examined by the hand from time to time, and whenever a tendency to chilling is discovered, hot bottles, hot bricks, or warm flannels, with some warm drink, should be made use until the temperature is restored....This fatal chill is most apt to occur towards early morning at the period of the lowest temperature of the twenty-four hours... (p131).

This is advice which a modern nurse would be familiar with, and the descriptions of temperature fluctuations are accurate. Nightingale also dispenses sound advice on

the disposal of body fluids, but again they are not described as such under the umbrella of 'infection control' as part of clinical governance procedures designed to ensure professional accountability as they would be today. Rather she puts the welfare of the patient as the overt focus of her advice, and whilst describing how important it is to maintain cleanliness in a patient's room, notes that she has observed 'sisters' scrub floors on their knees rather than let one of their patients sleep in a dirty environment. Tellingly, she notes that although she is not advocating that skilled nurses routinely do this work, nurses who wait for a maid to scrub the floor "...when their patients are suffering, have not the *making* of a nurse in them," (p134).

Nightingale appears to successfully integrate what might be termed 'theoretical' and 'practical' knowledge with the spiritual and moral component of nursing throughout her writing. Her attention to detail is astounding. In relation to noise, Nightingale reminds nurses that "The fidget of silk and crinoline, the rattling of keys, the creaking of stays and of shoes, will do a patient more harm than all the medicines in the world will do him good" (p152). She tells nurses to sit down when talking to a patient, to give the patient their complete attention, and to remain in the patient's view, so they would not have to expend energy turning their head to look at their nurse. She also notes that valuable energy is expended in speaking, so nurses should not ask patients to repeat themselves. Nurses are told not to:

> ...lean against, sit upon, or unnecessarily shake or even touch the bed in which a patient lies. This is invariably a painful annoyance. If you shake the chair on which he sits, he has a point by which to steady himself, in his feet. But on a bed or sofa, he is entirely at your mercy, and he feels every jar you give him all through him, (p156).

And even, in relation to drinking:

> ...take care not to spill into your patient's saucer, in other words, take care that the outside bottom rim of his cup shall be quite dry and clean; if, every time he lifts his cup to his lips, he has to carry the saucer with it, or else to drop the liquid upon, and to soil his sheet, or his bed-gown or pillow...you have no idea

> what a difference this minute want of care on your part makes to his comfort...(p168)

Understandably, there is no reference to research or evidence-based practice here, and this 'advice' is not necessarily only applicable to 'trained nurses', indeed the above was written at least two years before the first probationers commenced their training at the Nightingale School. This 'knowledge' arises from, and is firmly rooted in practice, the practice of every day life, of the home, of mothers tending children and of those looking after sick and vulnerable members of the household, and yet it is made available by Nightingale to any reader as a series of instructions - practice informing future 'nursing theory' - if we accept the terminology used and analysed earlier in this chapter. I would suggest Nightingale is writing here as a 'virtuous agent' in the Aristotelian sense, her moral and spiritual knowledge informing and being informed by 'theoretical and practical' knowledge - the sick and vulnerable are clearly at the forefront of the writer's mind. An examination of the following three texts however will illustrate how the emphasis on moral and spiritual knowledge may have shifted during the last century.

(ii) Mary Powell: Orthopaedic Nursing 6th edition 1968

Mary Powell was the Matron of the Robert Jones and Agnes Hunt Orthopaedic Hospital, Oswestry and is thus writing from a practice-centred position. It is notable that the foreword to this text is written by a doctor, that is, a consultant orthopaedic surgeon. The book is a key text of nearly 700 pages and its subject is that of orthopaedic nursing, a specialism which requires a great deal of 'theoretical knowledge' of bones, joints, and the influence of weights and forces on the skeleton. The orthopaedic nurse also requires extensive knowledge of how to apply splints, plaster of Paris, and traction devices, in addition to the psychological care of a patient who may be immobilised for long periods of time in hospital and require rehabilitation before and after discharge. The chapters follow a similar pattern to each other, so

comments on the weighting given to descriptions of anatomy, practical tasks such as the application of plaster and the specifics of nursing care are generalisable - the excerpts illustrated here are therefore as representative of the entire text as possible.

Powell recognises the importance of knowing 'that', indeed she notes:

> Since orthopaedic work is concerned with derangements of the form and function of the body, the student must gain a sound knowledge of the position, structure and function of bones, joints and muscles, especially those which are of special significance in the work she is doing...she cannot nurse her patient intelligently if she doe not carry in her mind's eye a picture of his broken bone, diseased joint or severed tendon; moreover she cannot recognise and report on the onset of complications, such as a drop-foot from pressure on the common peritoneal nerve, or the onset of radial palsy in a patient using crutches (p7).

This is a significant comment from a nurse writing at a time when nurses were trained in the 'apprenticeship' model, and perhaps should be born in mind when considering the criticisms of a supposed over-theorisation of nursing after Project 2000 was implemented, and as noted in chapter 1 of this thesis. Indeed, Powell devotes a chapter to the anatomy and physiology of the musculo-skeletal system, a chapter on the principles of genetics, (written by a research biologist), and describes the signs and symptoms of each condition requiring nursing intervention. For example, a fracture of the mid-shaft of femur is described in terms of how the bones and muscles are displaced - signs of deformity, rotation and shortening of the leg. Medical treatment is described, i.e. immobilisation through traction, as was the case when the work was published - but is not the case today. This procedure is described in great detail despite the majority of the treatment being carried out by the surgeon - but is however consistent with Powell's comments on the importance of the nurse 'knowing that'. Interestingly, 'nursing care' of the patient with the fracture is only allocated six sentences and they are devoted to directions about the arrangement of the weights attached to the patient's limb providing the traction. (This is proportionally similar to that devoted to descriptions of, specifically 'nursing' care elsewhere in the book).

Movement of the bed is to be done carefully, not (explicitly) to avoid distressing the patient as Nightingale advised above, but to guard against the weights being disrupted. In relation to the care of patients with spinal injuries for which there may be little or no medical intervention able to effect an improvement or cure, a much greater emphasis is given to nursing procedures such as the regular turning of patients to prevent the formation of pressure sores and the importance of maintaining adequate nutrition. In respect of the latter, Powell notes that patients must be fed "...patiently, unhurriedly, cheerfully, with every drink and meal of the day..." (p447).

A much greater emphasis is placed by Powell on knowing 'that' in relation to nursing 'tasks' such as the application of plaster of Paris splints to limbs. For example, her description of the preparation of plaster bandages is presented as a series of direct instructions:

> Each bandage must be torn separately, about ¾ inch wider than the width required. Remove five threads from each side, otherwise these will become detached when the bandage is used and form strands which will form pressure sores and/or interference with circulation (p32).

In respect of the application of a plaster bandage, Powell again provides detailed instructions:

> The bandage is rolled round the limb, and contact between it and the part to which it is being applied must always be maintained...when changing direction so as to follow the contour of the limb, take a tuck at the upper or lower edge of the bandage. Always cover two thirds of the previous turn and smooth the plaster continuously with the free hand (p36).

I would argue that no-one would be able to apply a plaster bandage *merely* on the basis of reading Powell's text. Indeed Powell herself admits that her book is meant to "...assist the orthopaedic nurse to a deeper knowledge of the needs of her patient, so she can develop her art to the highest degree" (p3). And also:

> ...moreover it is meant to be supplemented not only by wider reading, but by classroom and clinical teaching, and above all others by that means of learning which takes precedence over all others, and which can only take place at the bedside, i.e. practical experience (p.vii).

A consideration of moral and spiritual purpose is evident throughout the book, but is accorded less overt emphasis than is the case in Nightingale's texts. However, an echo of Nightingale's attention to basic detail can be seen in Powell's noting of factors which might prevent the patient's achieving the rest they require to recover, including cold, noise and thirst. Nurses should use "...control, judgement and attention to nursing detail as to use it to the best possible advantage..." (p23).

(iii) Winifred Hector: Textbook of Medicine for Nurses (1973)

Winifred Hector writes in her preface to this key text of the 1970s, that the purpose of her book is to promote understanding of the physiology of disease as nurses require this knowledge to understand "... why symptoms arise in medical illnesses, and the reasons for a particular method of treatment ..." (preface). Interestingly, as with Mary Powell (above), she has accepted the input of a medical doctor, and indeed admits:

> Although the writing of the text was done by a nurse, the project was the result of collaboration between a tutor and a physician. Dr. Hamilton Fairley read each chapter, offered suggestions and emendations, and taught his colleague a great deal. Without his knowledge, the book could not have been written (preface).

In every chapter Hector adopts (as does Powell) the approach of describing the anatomy and physiology of the organ or system under consideration (each system, e.g. the renal or digestive system, is given its own chapter). She then proceeds to describe the signs, symptoms and medical treatment associated with, for example, *inter alia,* renal (kidney) failure. Nursing input is described briefly in terms of the prevention of some cases of acute renal failure and includes observing for a fall in blood pressure and the avoidance of giving mismatched blood transfusions. In most

chapters however, there is no specific mention of nursing care at all, although given Hector's stated aim for the book, this is probably unsurprising.

The knowledge contained in this text is 'theoretical' and medically orientated. The author does not attempt to describe nursing practice, and displays little or no guidance on the moral and spiritual purpose of the nurse when caring for patients suffering from the conditions described. This is in contrast to Mary Powell who, despite adopting a similar medical framework, writes about the specific needs, both physical and psychological, of orthopaedic patients who may need to spend long periods of time in hospital. In addition, the deferential tone in Hector's introduction to the effect that without Dr Hamilton Fairley's knowledge the book could not have been produced, illustrates perhaps a lack of confidence in the knowledge base of nurses at the time.

(iv) Penelope Hilton (ed): Fundamental Nursing Skills (2005)

This contemporary text is notable in that all the contributors are nurses, as is not the case in both Mary Powell and Winifred Hector's texts. The publication avoids the format of describing a condition, its signs and symptoms, its medical treatment and only describing specific nursing care as an addendum. It therefore displays a measure of confidence in the existence of a body of nursing knowledge, something lacking in the previous texts, apart from, arguably, that of Nightingale.

Penny Hilton adopts a very nurse-orientated rather than medically-orientated approach, with each chapter describing an 'activity of daily living' as found in the theoretical model of nursing formulated by Nancy Roper, Winifred Logan and Alison Tierney (1996). Roper, Logan and Tierney's model of nursing is based on, *inter alia* what they describe as twelve 'activities of daily living'. These activities are, maintaining a safe environment, communication, breathing, eating and drinking, elimination, washing and dressing, thermoregulation, mobilisation, work and play,

expressing sexuality, sleeping and death and dying. The 'theory' underpinning the model assumes that by assessing the ability of a person to carry out each individual activity, it is possible to plan and carry out appropriate nursing care directly tailored to that individual's needs. The patient is regarded therefore as a unique individual and nursed as such, rather than, as it could be argued in the case of Powell and Hector's texts, the 'patient with a fractured femur', or 'with renal failure'. Chapter 1, for example, is focussed on the activity of breathing and includes basic anatomy and physiology in a similar manner to the Powell and Hector texts. However, in a departure from the Powell and Hector formats, Hilton devotes the majority of the chapter to the *nursing* assessment of breathing, and includes necessary observations such as the rate of breathing and the depth and degree of effort required.

Although the text illustrates a (in my view, welcome) focus on 'nursing' rather than on medicine, the knowledge presented appears to lack an expression of moral and spiritual knowledge found in Nightingale's and, to a much lesser extent, in Powell's works. Information is presented in tabular format - each procedure is matched with a rationale. For example, one of Nightingale's recommendations cited earlier, that the nurse should ensure no liquid is spilt in a patient's saucer, thereby avoiding spillage on his clothes, is described by her as aiding his *comfort* to a degree which is unappreciated. In the chapter focused on eating and drinking in the present text (chosen to enable a direct comparison), the author (Catherine Waskett) merely tells readers to provide a napkin (the *procedure*) "...to protect the patient's clothing" (p150) (the *rationale*). There is a major qualitative difference in the approach of these two authors writing nearly 150 years apart about a simple aspect of nursing care. The objective of the 'procedure' is the same (not to spill liquid on the patient) but I would ask whether a student nurse, by merely reading *this* text, would appreciate what it 'feels' to be a patient being offered a drink from a cup sitting in a wet saucer. If the student does not obtain this aspect of knowledge from this source of 'theory', then is

she or he going to learn to be a truly 'virtuous agent' from 'doing good' by working alongside their mentor in the clinical area? One would hope so, but it would seem dependent on the source and the manner of the mentor's learning too.

2.5 Conclusion

The arguments presented above would appear to indicate that the need to distinguish differing 'types' of knowledge is longstanding and indeed that our educational system, particularly in vocational subjects, is grounded in such distinctions. This chapter however should also have demonstrated that the terminology used in these texts is not necessarily precise enough to describe some of the actions carried out by nurses or indeed any other occupation which is practically orientated. Some nursing procedures are apparently taught as a series of instructions in theoretically orientated lessons in the university, and yet are later taught once more in the practical, clinical environment. Can the knowledge required to carry out a particular procedure be described as 'theoretical' or 'practical', knowing 'that,' or knowing 'how'? The question of which needs to come first is also left open by many authors. As has been shown, the NMC in particular is very clear that there is a distinction between the two and prescribes a precise balance of 'theoretical' and 'practical' instruction required prior to registration as a nurse, but has little to say on how and where that knowledge should be taught. It has been suggested above that there may be something contextually different in the process of transmitting this knowledge. The issues a university lecturer emphasises in describing the steps required to perform the procedure (e.g. in the case of inserting a naso-gastric tube, 'ensure the tube does not enter the lungs by asking the patient to swallow when he feels it at the back of his throat') may be rather different to those a staff nurse describes verbally and *demonstrates through his or her actions* when teaching and supervising a student performing the same procedure in practice (e.g. 'reassure the patient that this is a common and relatively risk free procedure by using appropriate verbal and non verbal communication - try putting

your free hand on his shoulder to reassure and distract him while threading the tubing'). But is this difference in context and content enough to justify categorising knowledge in such a way? The existence of and need for 'moral and spiritual knowledge' has also been identified both in the wider sense of the acquisition of 'internal goods' (Dunne 2007), the promotion of the good of the profession (Standish 2007), and in the Aristotelian concept of *phronesis.* Finally, the emphasis given to the three 'types' of knowledge has also changed somewhat over the time span covered by the texts analysed at the end of this chapter. Although only a small number of texts were examined in this thesis, there appears to be now less emphasis given to the moral and spiritual aspect of nursing, the identification of need, procedure and rationale gradually taking precedence over any attempt to persuade the student reader to empathise with the patient, to imagine, *how it feels.* 'Theoretical', 'practical' and 'moral and spiritual' knowledge will be revisited in chapter 4, where further arguments will be presented in a discussion about these concepts and their place in nursing education.

Chapter 3: What is a Nurse?

Introduction

The texts analysed in the previous chapter reflect that nursing has indeed changed dramatically since Nightingale's 19th century reforms although this has not always been accurately reflected in the media and in the imagination of the general public. This chapter will begin with a historical analysis of media portrayals of nurses and nursing. It is important to do this as it is argued (notably by Hancock (1999)) that the media may have some influence on public opinion and on national policies shaping nursing education. Articles in the Press, such as those which preceded the Evaluation of Project 2000 by Leonard Peach, *Fitness for Practice* (UKCC 1999) and discussed in chapter 1, illustrate that writers appear to have a very definite construct of a 'nurse' in mind when opining on what they think nurses need to know. Also to be analysed are attempts at definitions of nursing by academics and professional bodies and, in addition, policy documents issued by government departments outlining governmental expectations of the role of nurses in the future.

The history of nursing education has, as has been discussed in the previous chapter, been preoccupied with the emphasis and balance to be given to Nightingale's three mainstays of theoretical knowledge, practical knowledge and an underpinning moral and spiritual knowledge which she and countless others have termed 'vocation'. It has been suggested that the weight given to this latter aspect of knowledge has declined over time, at least in the texts analysed in chapter 2. Yet the emphasis to be laid on each of these components during the education and training of student nurses should surely be influenced by an answer to the question, 'what is a nurse'? Indeed it is not only in the field of education that the question is of importance. The Royal College of Nursing (Royal College of Nursing 2003) has made it clear that those

consortia of organisations (including NHS Employers representatives, NHS managers, and social services representatives) responsible for providing health care, purchasing services and charged with commissioning nursing education, also need to understand the nature of nursing and the role or roles of the nurse.

Decisions on how many nurses will be required by the NHS and the private sector in the next three years for example, surely cannot be made without an understanding of the nature of the role of the qualified nurse. Assumptions made by non nurse representatives in relation to 'productivity' and costs when determining an optimal mix of skills in a nursing team or ward, if founded on ignorance (Patterson 1992) may well lead to future problems of supply and demand. Indeed, Humphreys (1996) notes the evidence that although commissioning consortia of local employers could have a profound impact on the form of education their future nurse employees undergo, many agendas focus on the 'business end' of operational issues, such as staff student ratios in the workplace, student selection and the availability of clinical placements in their organisations.

3.1 Media representations of the nurse

The following discussion contains extracts from literature, film and television. The examples of representations of nurses in the media have been chosen because they appear in popular, widely read and widely viewed media and therefore are those most likely to have been seen and perhaps had the most influence on the public imagination. It is the image of the nurse in the public imagination which, I argue, influences and drives discussion on both working practices and nurse education.

The Witch

One of the earliest major representations of the nurse disseminated through a major publication, was that of Sairey Gamp, created by Charles Dickens in his novel *The*

Life and Adventures of Martin Chuzzlewit (1843-4, published serially). Gamp was portrayed as an uneducated, unclean, drunken woman whose major function seemed to be that of watching over the sick (whilst also mistreating them) and performing the laying out of the dead. Dickens has been lauded for creating the character as a spur to a reformation of nursing and nurses themselves. For example, a contemporary of his, S. Squire Sprigge - a physician, noted:

> With regard to the nurses, Dickens...helped in a very pronounced degree to rescue society from the ministrations of the hopeless class into whose hands the calling of nursing was committed. Society owes Dickens a double-debt, for having buried the nurse-hag under inextinguishable laughter (1877, p258).

However, taking a more feminist perspective, Leslie Fiedler (1989) argues that Dickens' portrayal of Sairey Gamp is also based on the fear and dislike of the traditional 'wise women' folk healers described by Ehrenreich and English (1973), in chapter 1 of this thesis. These women were, as Ehrenreich and English note, often portrayed as witches. And as Fiedler goes on to say:

> It is in any case as a Witch, albeit a comic one, that Sairey Gamp is portrayed: one in whose unclean hands all three traditional functions turn malign. Not only does her actual practices travesty the role of bedside healer to which she lays claim; but even more as a midwife and layer-out of the dead her skills are shown as debouching in mutilation and monstrosity (p105).

Fiedler traces similar attitudes towards nurses (which she argues are based on an inherent male fear of female power and sexuality) through twentieth century literature, film and television programmes. She cites in particular the character of Nurse Ratched, known as 'Big Nurse', in Ken Kesey's (1962) novel and later, film *One flew over the Cuckoo's Nest.* The story is set in a psychiatric ward of a state hospital. Nurse Ratched is feared by the male patients as a man-hater whose aim is to cure them of psychiatric illness, and for the main male character her actions are seen as "...force [ing - DC] all psychological deviants into conformity with the system...a kind of ball-breaking: a war against manhood, which beginning with the administration of

tranquillisers, moves onto electroshock therapy and reveals its true motive which it climaxes in lobotomy – that ultimate form of castration" (p111).

Philip and Beatrice Kalisch (1987) also interpret Nurse Ratched in a similar manner, describing her as needing to exert power as she "...ruthlessly guarantees that her patients will not recover their autonomy and dignity....And finally, Ratched stands as a symbol of spiritual death" (p175).

Both Fiedler and Kalisch are describing misogynistic attitudes arising from "...the dark side of our ambivalence toward both those who bear us and those who tend us when we are ill" (Fiedler 1989, p111). Dickens made Mrs Gamp hit her patients and pinch their noses to make them swallow their medicine. She was a woman 'in control' of a helpless patient. Dickens did not endow her with a sense of competence and professionalism however. Indeed, Fiedler does not credit Dickens with using Gamp to argue for more professional nurses, rather she argues that whilst he disparages the 'nurse as witch', he is also critical of the 'nurse as professional'.

One might also wonder whether the late twentieth century identification of 'nurse as sex symbol', described later, is a similar but 'modern' attempt to disempower the women who care for us.

In chapter headings and in his text, Dickens uses the word "professional" over and over as a term of contempt, making it clear that he objects not only to the shamanistic past of Nursing but to the scientific, bureaucratic future imagined for it by Florence Nightingale. Not only is he opposed to demystification - what he advocates is humanisation rather than professionalisation or certification. This he makes clear in the parting words of advice given by old Martin Chuzzlewit to a discomfited Mrs

Gamp "...a little less liquor, and a little more humanity, and a little less regard for herself, and a little more regard for her patients..." (1989, p106).

Nurse Ratched, in contrast, is not only a woman/witch, she is extremely good at being in control of her male patients, being a trained nurse and displaying an aspect of professionalism lacking in Mrs Gamp. This makes her even more 'dangerous'. However, it is perhaps not her professionalism which seems to have 'perverted' the nursing role ("...warmly voiced concern for her patients' welfare...organisation and discipline ...maintenance of a secure and well-maintained environment...dedication to her job...") (1987, p175) but rather, as Kalisch et al argue, her obsessive-compulsive personality disorder. However, whether a significant proportion of the general public exposed to *One Flew over the Cuckoo's Nest* appreciated the influence of Nurse Ratched's mental ill-health on her actions is open to debate. I would argue a negative image of a *woman* in uniform, in power, without a family life of her own and occupied in disempowering her patients, is the more likely impression left on them.

The Angel

It was Florence Nightingale, as described in chapter 1 of this thesis, who initiated reform of hospital nursing. Her reforms were, *inter alia* aimed at addressing the deficiencies of the Sairey Gamp type of nurse and promoting a more respected and regulated profession. As has been noted, her aim was to provide women who needed to support themselves with a respectable occupation, inculcating obedience, humility and a sense of vocation through a structured, systematic, training programme. Nightingale herself was depicted in literature, and particularly poetry during and after her work in the Crimea, as a saintly figure carrying a lamp. It was the American poet, Henry Wadsworth Longfellow, who first wrote of the "lady with the lamp" in his poem *Santa Philomena* (1857):

> The wounded from the battle-plain,
> In dreary hospitals of pain-
> The cheerless corridors,
> The cold and stony floors.
>
> Lo! In that house of misery,
> A lady with a lamp I see
> Pass through the glimmering gloom,
> And flit from room to room.

And:

> A lady with a lamp shall stand
> In the great history of the land,
> A noble type of good,
> Heroic womanhood (22-23).

This poem would seem however, not to be lauding nurses in general, but Nightingale herself as a 'heroic' woman. Nightingale seems to have been imbued with an almost magical (angelic?) power, patients attempting to gain respite from suffering through merely kissing her shadow:

> And slow, as in a dream of bliss,
> The speechless sufferer turns to kiss
> Her shadow, as it falls
> Upon the darkening walls (22-23).

The 'angelic' image of the 'Nightingale' nurses working in the Crimea was also reinforced and promoted by other Victorian writers. Kalisch and Kalisch cite amongst others *Scutari Hospital,* a poem by R.N. Cust (1908), as an example of what they describe as "...the conventional poetic image of Nightingale as angel while it also invokes her as a symbol for the best kind of nurse" (1989, p18). Cust employs phraseology heavily imbued with religious overtones, describing nurses "Flitting like angels/from bed to bed" whilst the wounded patients offer up prayers of thanksgiving to them, "Many a blessing/many a prayer...from rough lips for/Those angels there" (p337). Unfortunately, these poems do not appear to give nurses any credit for having any form of nursing *knowledge* or skills other than perhaps by implication - they must have been doing something as they 'flitted' around the wounded other than "Wiping the clammy brows with tender hands" (1908, p18), to deserve the prayers of

thanks offered up for whatever service their patients received. Or perhaps in the circumstances of the overcrowded military hospital, that was all which could be accomplished by the nurses and the even meagre attention of female (mother?) figures at such a time was enough to trigger such emotions.

The angelic image of the nurse persisted into the twentieth century and was encouraged particularly in wartime. The First World War, 1914-1918, generated a series of films idealising the role of nurses. Kalisch and Kalisch trace the appropriation by the film industry of Edith Cavell, the English nurse who was arrested and ultimately shot by the Germans for assisting the escape of wounded Allied soldiers from Belgium. Cavell trained as a nurse at the age of 30 at The London Hospital and worked both as a private nurse, in Poor Law institutions and in a Queen's District Nursing Home. She then went to Belgium where she became Head of a pioneering training school for lay nurses in 1907. By 1914 she was not only training nurses for many hospitals and schools in Belgium but also delivering lectures to both doctors and nurses. However, both her clinical competence and knowledge were overlooked by film makers after her execution in favour of a continuation of the quasi-religious image. Two such films were titled *Nurse and Martyr* (G.B, 1916) and *The Martyrdom of Nurse Cavell* (Australia, 1916). Both these, and *The Woman the Germans Shot* (U.S, 1916) (amongst others), portrayed Edith Cavell (quite rightly) as a courageous woman, they also, according to Kalisch and Kalisch, utilised her status as a nurse which:

> ...sanctified and legitimized the actions of the heroine. In "The Woman the Germans Shot", Cavell was often portrayed clasping her hands and with eyes looking to heaven, or 'mopping fevered brows'. Not only did the nurse character provide a ready foil to Germanic malevolence, she also provided clear guidelines for female behaviour during wartime (1989, p48).

Interestingly, the image of Edith Cavell as a very young madonna-like figure in *The Woman the Germans Shot*, contrasts vividly with her statue sited outside Norwich

Cathedral, close to her grave. Far from being a young woman, Edith Cavell was 50 years old when she was shot, and in paintings and photographs produced before the First World War can be seen to be portrayed as a mature, confident woman whose eyes remain fixed on those of the viewer rather than being raised to heaven. This dignified image is also that reproduced in her memorial statue. In the cases of both Cavell and Nightingale, it would be difficult to imagine how anyone other than an assertive, determined and brave woman could have achieved as much as they, particularly in the late nineteenth and early twentieth centuries. Indeed, Dr Gottfried Benn, the German Medical Officer who attended Cavell's execution, noted:

> I closed her eyes and placed her body in the coffin. She was the bravest woman I ever met, going to her death with poise and bearing. She had however, acted as a man towards the Germans, and deserved to be punished as a man (Quote 43, Cavell, The First World War 2003).

This observation from someone who had direct contact with Cavell contrasts vividly with the propaganda - use to which Cavell's death was put in the films of her life noted above. Far from the media reconstruction of her as a passive victim - an 'idealised female' role model, it is perhaps ironic that Dr Benn should describe her as an active agent who behaved in a very male way - not an image which fits well with that of nurse as angel. Although Longfellow, in describing his image of Nightingale in *Santa Philomena,* uses the word 'heroism' (which arguably has masculine connotations) in conjunction with 'womanhood', he only does so in the context of Nightingale's 'flitting' around her hospital with her lamp, invoking the gratitude and worship of her patients. Unfortunately, the media representations of both women as nurses contained little which might raise public awareness of what it really meant to be a nurse - what did they need to *know?* What did they have to *do?*

The Wound Dresser is a poem which does describe *what* nurses do both in practical and in terms of spiritual care, and was perhaps not surprisingly written by a nurse.

Walt Whitman, the American author, poet and nurse, not only cared for wounded soldiers during the American Civil War, but was also a man, thus further confounding the image of the nurse as mother/angel. Whitman describes his duties in terms of hands-on nursing care which any present day nurse would recognise, and significantly his knowledge and skills are implicit in his verses:

> Bearing the bandages, water and sponge,
> Straight and swift to my wounded I go,
> Where they lay on the ground after the battle brought in,
> Where their priceless blood reddens the grass on the ground,
> Or to the rows of the hospital tent, or under the roof'd hospital,
> To the long rows of cots up and down each side I return,
> To each and all one after the other I draw near, not one do I miss
> (lines 25-31).
>
> ...I undo the clotted lint, remove the slough, wash off the matter and blood,
> Back on his pillow the soldier bends with curv'd neck and side falling head,
> His eyes are closed, his face is pale, he dares not look at the bloody stump...(lines 46-48).
>
> ...I dress the perforated shoulder, the foot with the bullet-wound,
> Cleanse the one with a gnawing and putrid gangrene, so sickening, so offensive,
> While the attendant stands behind aside me holding the tray and pail (53-55).
>
> Thus in silence in dreams' projections,
> Returning, resuming, I thread my way through the hospitals,
> The hurt and wounded I pacify with soothing hand,
> I sit by the restless all the dark night, some are so young...(59-62), (1865).

This description is some distance from Longfellow's and Cust's imaginings of the nursing duties of Nightingale in the Crimea, and is probably not only the more accurate, but it portrays to the reader the range of skills and the obnoxious nature of some of the tasks undertaken which greatly surpass the mere soothing of fevered brows by 'angels'.

Another aspect of 'nurse as angel', is that of using nursing as a means of moral regeneration, and is a theme explored by Kalisch and Kalisch in their analysis of Hollywood films depicting the First World War. They note that nursing often provided a route by which non-American women could escape a morally dubious existence

and "...return to a chaste state" (p54). For American women of good reputation who wished to volunteer to help the war effort, only nursing seems to have provided a route to fulfil their wishes as "Their nursing identification provided them with a symbolic protection of their reputations despite their wartime experiences" (p54).

This self sacrificing 'virtuous' work continued to be portrayed as such throughout the nineteen twenties and thirties, Kalisch and Kalisch noting that films of the era fostered an image of nursing as a calling almost akin to a religious vocation, particularly after the economic depressions of the era. Julia Hallam (2000) however, notes and interprets a change in attitudes to nursing in the Hollywood films of these decades. She points out that the Kalishes' analysis of the media of the 1920s showed that stories predominated where nurses were depicted as doctor's helpmates, commonly little more than receptionists in uniform, who gave up their profession to marry their (preferably) wealthy employer. Nursing was frequently shown to be a means to meeting a future husband rather than as a profession in itself. By the mid 1930s and into the 1940s however, nursing was portrayed as more of a lifelong calling and women were much more likely to be portrayed as sacrificing themselves to the profession and rejecting marriage. Hallam argues this may have been the result of a backlash against the materialism of the 1920s which was increasingly difficult to sustain during the economic instability of the 1930s. The nurses portrayed in films of this era, were moulded by the "...rigid moral code enforced on Hollywood by the Production Code, [which tended - DC] to polarise female characters into 'good women' and 'bad girls' ". Unlike in earlier films where "... it was possible for a 'bad girl' to redeem herself by becoming a nurse, in the 1930s nurses on the screen tended to polarise into 'good' and 'bad' types" (2000, p37). Hallam cites the film *Vigil in the Night* (1940), as an example:

> ...'badness' amounts to neglecting a patient to make a cup of tea...with the result that the patient dies. Throughout the film all the negative and critical

> comments about nursing are made by the Bad Nurse. Finally, she is punished for neglecting her duty; whilst nursing another child with smallpox, she contracts the disease and dies. The Good Nurse is rewarded with a doctor partner and is given the final lines of the film; 'We're here to serve, and if we do it well, we find pleasure, freedom, perfect freedom...' The moral of the film is clear: the wages of sin, (in this case putting one's own desires and needs before others), is death... Only through willing and obedient self sacrifice and service can a woman hope to find happiness and fulfilment....these women need the institutional context of nursing in order to function as 'good' characters (p 37).

Again however, media constructions of nurses are limited to commenting on and promoting a particular concept of female behaviour and tell us little about the process and outcomes of nursing, and the skills and knowledge required to achieve them. Indeed, Suzanne Gordon and Sioban Nelson (2005) argue that the promotion of nurses as angels or 'good' women (which they term 'the virtue script') continues today, and in particular, in recruitment advertising campaigns. They note that in their analysis of recruitment literature (albeit from the United States), much is based on the traditional stereotype of the good, self sacrificing woman. It is difficult to argue against the need for good, self sacrificing women (and men), however, as Gordon and Nelson point out, this seems to be at the expense of the promotion of a nurse:

> ...educated to provide care based on science and practical skill. Although many studies - conducted by nursing, medical and public health researchers – have documented the links between nursing care and lower rates of nosocomial infections, falls, pressure ulcers, deep vein thrombosis, pulmonary embolism and death, most promotional campaigns are conspicuous for their failure to promote these data (2005, p63).

The outcomes of the promotion of the 'virtue script' are profound, and influence the ways in which the general public and policy makers think of nursing and the importance they give to nursing care in relation to medical interventions. Gordon and Nelson (2005) cite the words of the actor Christopher Reeve who was paralysed in a riding accident, in his book *Still Me* (1998). He described the work of the doctors during his stay in intensive care in great detail as they worked to keep him alive. However, as far as his nurses were concerned he only appeared to note their

gentleness and sympathetic voices. He also remembered his favourite nurse taking him up to the hospital roof to watch the sun rise one morning. As Gordon and Nelson point out "Whilst this is certainly part of good nursing care, Reeve had made it the totality of nursing care" (p67).

The Housewife and Mother

The 1950s and 1960s were for Kalisch and Kalisch characterised by media representations of the 'nurse as housewife'. This again mirrored (male) societal demands that women return to the home after the 1939-1945 War. They note that the majority of nurse roles in both film and paperback novels involved nurses looking for marriage and therefore inevitably to leave nursing. Fulfilment is gained not through carrying out a professional role but through supporting a doctor, a husband, or both, through personal or professional crises. Nursing knowledge and expertise appears therefore in the examples cited by the Kalisches to be heavily focussed on nurturing, a characteristic admired by potential husbands. Indeed, nurses portrayed in paperback novels of the time also appear to be preoccupied with finding romance rather than with studying or worrying about their patients' welfare. Kalisch and Kalisch also note that "The tendency for fiancés to be physicians is significant. The doctor-nurse relationship of command and obedience supplies a highly traditional model for husband-wife relationships in many romances" (p143). They cite an extract of dialogue from *Nurse on Pondre Island* (Bowman 1965):

> "Riney, I haven't asked you if you'll marry me, Will you?"
> Primly she replied, "Now, Dr. MacDonald, when has a nurse ever defied a doctor's orders?"
> "Then I order you to." But he found a demonstration more forceful than words (1965, p120).

Unsurprisingly then, nursing skills as perceived (and valued highly) by the authors of these novels are those reflecting traditional 'housewifely' tasks such as cleaning, making beds, folding and sorting linen, preparing and serving food and caring for the

sick, whether as hospital patients or as members of her family. Indeed, I can personally remember recruitment literature from the late 1960s pointing out that becoming a registered nurse was an excellent training for marriage and motherhood. Hallam (2000) argues the hospital was portrayed at this time as "...a microcosm of home life; doctors are fathers and husbands, nurses wives and mothers, and the patients their children" (p50). In support of this view, I can also remember that during the period of my training in the early 1970s, male doctors would carve the Christmas turkey in the hospital staff canteen, in presumably a similar manner to that of the middle class father of the family carving the meat at the head of the family dining table.

Even when nurses were portrayed as having a degree of clinical knowledge and skill and were shown to be practising these, as in the *Cherry Ames* books of the 1960s, Hallam notes that nursing, for Cherry, is ultimately only a job whose attributes appear to be adventure and travel, rather than professionalism and patient care. However, despite the emphasis on images of nurses framed within the patriarchal family of hospital and home in the literature of this period, Hallam also describes a more positive image. She notes that "In many of the texts, the picture is one of nurses as a competent and capable group of women who quite often do the thinking for men, but never take the credit for it" (p72). This image is of course on the one hand positive, in that nurses are credited with thinking, but on the other negative, in that the thinking has to take place within the paradigm of female self sacrifice for the good of duty and/or the male doctor. Once again, the stereotype provides little in the way of information on *what* nurses really do and what they need to *know.*

The Sex Object

Kalisch and Kalisch (1987) describe the emergence of the media image of the 'nurse as sex object' as "...the most negative media image since Dickens's Sairy Gamp"

(p156). They trace the phenomenon to the social and sexual revolution of the mid 1960s and blame the advent of an increased role for women in the workplace, greater availability of effective contraception, and rising divorce rates. It remains unclear to me however, why nurses in particular should be 'transformed' in such a manner, as these social factors would seem to affect most women. Leslie Fiedler (1988) perhaps goes some way to explaining the phenomenon more convincingly when she describes (female) nurses perceived as 'willingly subordinate', not only to doctors, but also to their patients, and also having almost a unique status amongst women in relation to men:

> After all, nurses preside at the bedsides of males-privileged, even required, unlike other members of their sex, except for prostitutes, to touch, handle, manipulate the naked flesh of males. And they tend, therefore to be presented as erotic figures of a peculiar, ambiguous kind (p101).

This ambiguity, according to Fiedler, consists of the wearing of the starched, white uniform, almost nun-like until relatively recently, allied with the male fantasy of the sexually desirable and always willing nurse, who is familiar with and has 'permission' to touch their bodies. However, no matter how persuasive this analysis of male attitudes towards nurses might be, the question of why 'nurse as sex object' came to the fore relatively recently remains. Perhaps the most likely explanation is, 'nurse as sex object' always existed, but was unable to find expression in the mass media because of public propriety and censorship. The Kalisches' argument is also that a more permissive society in relation to sexual behaviour, and the gradual relaxation of public attitudes to the depiction of sex in film and television, facilitated the exposure of male fantasies which would have previously remained hidden. This can be seen in a longitudinal analysis of the nurse characters in the "Carry On" series of films. As Kalisch and Kalisch (1987) also point out, the first Carry On film set in hospital, *Carry On Nurse* (Governor Films 1959), portrays nurses in a manner congruent with its time and the categories described above. The Matron is efficient and dignified as an older,

experienced nurse might be expected to be, as is the Ward Sister. The much younger Staff Nurse is admittedly a glamorous blonde who is anxious to please the doctors and has romantic aspirations in respect of one of them. She is also however, compassionate and professional in both her attitude to the patients who express romantic feelings towards her, and in the way she wears her uniform. She also appears to be articulate and middle class. There is an assumption that her aspirations are to make a good marriage with one of the doctors. The next hospital based film in the series which was released in 1967, *Carry On Doctor* (Rank), shows the Matron as an "...utterly nonsensical caricature, pursuing and pursued by doctors, and getting involved in the most demeaning nonsense..." (1987, p165). The degeneration of the character of Matron, is mirrored by that of the Staff Nurse. The Staff Nurse in the later film is played by Barbara Windsor who plays the character as a cockney (by implication, working class) blonde in a very short uniform dress. Kalisch and Kalisch describe her as placing the nurse character "...on a new plane of suggestiveness and smut" (1987, p165). They describe the evolution of both characters in these two films and in the later *Carry On Matron* (1972, Rank), as a ridiculing of nurses and as illustrating the shift in attitude from the nurse as housewife and mother of the late 1950s to that of the Barbara Windsor character "...an obvious joke nurse", who was "...a dishevelled doxy" (p166). They go on to claim:

> Instead of laughing *with* the nurses at their lot, over the years the "Carry Ons" inexorably began to laugh *at* them: not as individuals, which in some measure the nurses in *Carry On Nurse* remained, but as stereotypical robots, copied from a sexist world (1987, p166).

The problem with the Kalisches' claim that attitudes have shifted, is that they appear to be arguing that this was consciously intended by the script writers and directors of these films and, in addition, that they intended to denigrate *nurses* in particular. There are two major objections to their theory.

The first is that they have already noted that society in general was changing rapidly in the 1960s and 1970s and that censorship of the media was becoming increasingly relaxed. Therefore I would argue the scripts became more 'smutty' because they *could.* I would also argue the changes in attitude towards both nurses and doctors in these films was more likely to be a reflection of changing attitudes towards authority figures in general during the 1960s and 1970s, and with these changes came a tendency to ridicule and criticise. It should also be noted that Kalisch and Kalisch are writing from a North American perspective. Appreciation of comedy can be argued to be very culturally specific, and the "Carry On" films are a peculiarly British phenomenon. The Kalisches' depiction of Matron as experiencing a diminishing of "her stature and moral fibre" (p166), as she is shown to be "...sex mad and easy prey for male physicians..." (p166) is arguably a misreading of the storyline. It is actually Matron (Hattie Jaques) who fends off the attentions of Sir Bernard Cutting, the surgeon (played by Kenneth Williams), and insists (successfully) on marriage before allowing any further sexual attention from him. Matron is patently always in control of the relationship. The Kalisches' criticism also takes no account of the cosy familiarity and affection British audiences would have with Hattie Jacques and Kenneth Williams and that the story line relies heavily on irony - no British audience would take the amorous attempts of the two characters particularly seriously and would I suggest still be laughing *with* the characters rather than *at* them.

The second objection to the Kalisches' argument is that it was the nurses in these films who were targeted for attack. An analysis of *Carry On Matron* reveals that the character of the consultant (Sir Bernard) is considerably more 'ridiculous', being portrayed as a hypochondriac and easily manipulated by Matron. The other doctors in the film are Dr Prod, an unattractive lecherous character who unsuccessfully tries to seduce one of the nurses, and Dr. Goode, an eccentric psychiatrist. Both are depicted as needing guidance and the occasional reprimand from Matron. The

character of Matron patently displays the more professional behaviour towards patients and staff - she is attentive, constantly patrolling the wards and concerned with her patients' welfare. It is the doctors who are portrayed as being disinterested in their patients, behaving incompetently, and who merely sanction Matron's requests for treatment to be initiated. Doctors could therefore also argue that in comparison with *Carry On Nurse*, released in 1959, the deferential attitude afforded to them particularly by nurses in that film had disappeared. However, perhaps doctors do not feel the need to complain, having the greater self confidence in their position and abilities.

One example of a portrayal of nurses which does not appear to rely heavily on the stereotypes illustrated above, is that of a hospital based drama currently showing on British television. *Casualty* (BBC Television, 2007) was first screened in 1986 and has consistently shown nurses as competent and knowledgeable, albeit with a plethora of personal problems to overcome. Unusually, it has also introduced many male nurse characters, and indeed the senior manager of the department is a male nurse, Charlie (Derek Thompson). *Casualty* shows nurses participating in resuscitation attempts, dressing wounds, inserting sutures and addressing the psycho-social aspects of patients' problems. In this, it mirrors much more accurately the working lives and the range and depth of knowledge and skills of 'real' nurses than any of the examples of 'media' nurses described above. The prominent roles given to men as nurses is also a departure from the media stereotypes of nurse as angel, housewife and mother, and sex object. Hallam (2000) reports that "...the Royal College of Nursing suspects that the portrayal of male nurses in *Casualty* has influenced an increase in male recruitment from under 10 per cent to more than 15 per cent of student applications" (p197). However, Hallam also argues that the character of Charlie is merely that of the familiar "...caring male medic..." (p194), and as such could be a doctor, nurse, or as is also often the case in *Casualty,* a male

paramedic. She claims that by making Charlie a nurse, the programme makers are only meeting a need to be seen to be addressing 'equal opportunities' and 'progressive' programming. This perhaps does not do the character enough justice, as Charlie is not only a caring *man*, he is a caring *nurse*, and as such he acts as a nurse both in respect of engaging as patient's advocate against both over zealous doctors and hospital administrators and in defending his nursing staff against excessive demands made on them by the same. His character is mirrored by that of Robert Powell's senior nurse in *Holby City* (BBC Television, 2007) which is set in the same hospital. Powell is portrayed as a specialist, often advising doctors, and on one occasion when a doctor could not be found in time, inserting a chest drain, thereby saving a patient's life. Although there are many instances in both programmes of 'negative' stereotyping (nurse as sex object is still evident in both), these programmes do give the general public an awareness of the depth of knowledge and skills required by nurses and provide positive role models of male nurses.

The role of the Nursing and Midwifery Council (NMC) has come under some scrutiny from Hallam (2000). She notes that their and other professional bodies' view on negative stereotyping appears to be that "...it is better ignored, rather than discussed or aired. This silence still meets those who try to open up debate on the subject, as I discovered in my initial attempts to research it" (p77). The strategy of ignoring stereotyping is reinforced by Andy Jaeger, writing in NMC News (2007), a publication received by all nurses currently registered with the NMC. He describes many of the negative stereotypes featured in the films and television programmes already referred to in this chapter, but claims in fact that they do not matter, and that the public is aware that these stereotypes "...don't match up to the real life nurses they meet in hospitals, surgeries and clinics" (p30). He goes on to say "...the way you treat people every day matters so much more than Barbara Windsor taking her top off" (p30).

I would argue that he is underestimating the power of the media in transmitting subliminal images of nurses. As the focus of this thesis is nurse education, the question arises of whether the nurse stereotypes illustrated above should concern those involved in designing and delivering nurse education. I have attempted to point out throughout this chapter, the argument that both the public and policy makers gain many of their beliefs about what nurses do, and therefore what nurses need to know, from these media images and others like them. In chapter 1, I noted that Christine Hancock, then General Secretary of the Royal College of Nursing, felt the need to defend the more academic emphasis of Project 2000 against journalists who were claiming nurses were wasting time in classrooms and becoming 'over educated' in relation to what those writing assumed to be a rather restricted nursing role of, *inter alia,* taking blood pressures and administering bed pans. Kalisch and Kalisch (1987) reinforce this view of the media's power and influence in particular in relation to the lack of role models for men in nursing and the subsequent barrier this creates in trying to recruit nursing students from at least half the population. Constant media representations of nurses smoothing bed sheets and mopping fevered brows, or engaging in sexual contact with doctors and patients, devalues real nursing work and therefore the educational provision required to achieve it. Equally, the promotion of an image of self sacrificing martyrdom, which arguably also affects nurses themselves on a subconscious level, is a convenient method of social control, and results in a workforce willing to endure heavier workloads in the (short term) interests of their patients and a reluctance to strike for better working conditions or pay. This has implications for the both patients and the development of the profession.

3.2 The views of nurses

Many nurse authors have attempted to define what nursing work might be. Once an appreciation of the scope of that work is gained, it should be possible to ascertain the scope and level of knowledge and skills that person may require to carry out their role

as a nurse. The question therefore to be asked is, what is different about what a nurse does to the work of, for example, someone caring for a relative at home, or perhaps a 'health care assistant', a person increasingly relied upon by the Health Service? Nursing literature draws heavily on the work of two major writers, Florence Nightingale and more recently, Virginia Henderson. I have therefore, decided to concentrate on the views of these two authors who were writing approximately a hundred years apart, the former in the late nineteenth century and the latter in the late twentieth century. I will also include within this section definitions of nursing formulated by the Royal College of Nursing, the rationale being that this body is made up of nurses and its remit is the promotion of their professional development and personal welfare.

Florence Nightingale

As has been noted in chapter 1, Ehrenreich and English (1973) claim that prior to Nightingale's reforms of nurse training in the mid 19th century, the term 'nurse' was generally applied to any woman who happened to be looking after a sick child or elderly relative for example. However, Florence Nightingale herself wrote in her 'Notes on Nursing' (1859), "It has been said and written scores of times, that every woman makes a good nurse. I believe, on the contrary, that the very elements of nursing are all but unknown" (1859, in Seymer 1954, p124). Despite this statement, Nightingale wrote extensively on what she believed to be the aims and the components of what she also termed, the 'art' of nursing. She identified that the description 'nursing' had once been used to describe certain acts – for example, of applying poultices and of administering medicines, and had been limited to such. Nightingale then expanded its remit to "...signify the proper use of fresh air, light, warmth, cleanliness, quiet, and the proper selection and administration of diet – all at the least expense of vital power to the patient" (1859, in Seymer,1954, p124). Nightingale also astutely differentiated between nursing and medical care and

identified an issue which has some contemporary significance, that of the value both economically and in the minds of the public which patients place on one or the other. She noted:

> "...- so deep – rooted and universal is the conviction that to give medicine is to be doing something, or rather everything; to give air, warmth, cleanliness, etc. is to do nothing. The reply is, that in these and many other similar diseases the exact value of particular remedies and modes of treatment is by no means ascertained, while there is universal experience as to the extreme importance of careful nursing in determining the issue of the disease (1859, in Seymer 1954, p125).

The provision of fresh air, warmth, a hygienic environment, rest, and appropriate food, was reiterated by Nightingale throughout her writings. As she pointed out, these requirements are equally applicable to the well person, and any lack will have deleterious consequences for the healthy, albeit with probably less serious consequences than for the sick. Nightingale was at pains to point out that providing the above conditions was well within the capabilities of mothers who could improve the health of their children and families by simply improving the conditions in which they lived - there was no need, Nightingale stressed, for specialist medical knowledge and the intervention of doctors. She criticised calls for the establishment of more Children's Hospitals with the aim of reducing large scale child mortality, claiming correctly that child deaths could be more effectively reduced through better *home* hygiene. In this she was laying the foundations of public health nursing and therefore widening the definition of nursing from that as merely a 'bedside' occupation practised in hospitals.

Nightingale also needed to address 'bedside' nursing of course and, in addition to the above requirements, she added to the nurses' duties those of informed observation, the 'application of remedies', which would include, *inter alia,* pharmaceuticals, dressings, poultices, enemata, injections, the insertion of catheters, inhalations and the management of leeches. The nurse should be able to administer first aid to stop

haemorrhages, assist the surgeon in the operating theatre, and interestingly, as washing is not a task perhaps seen as particularly skilled by the public at the present time, be able to wash a patient's whole body "... *without exposure or chill to any part*" (Nightingale's italics), (1859, in Seymer 1954, p347). She also required the nurse to be able to anticipate a patient's needs so skilfully they only realise they are being nursed well through perceiving they have *no* needs.

The 'nurse' able to deliver the above requirements also needed for Nightingale, a very good character, and to be sober, honest, truthful and trustworthy. The nurse also needed to be able to learn new skills, as knowledge of medicine, hygiene and surgery increased. The nurse was required therefore to be 'educated', as Nightingale put it:

> An uneducated man who practises physic is justly called a quack, perhaps an impostor. Why are not uneducated Nurses called quacks and impostors? Simply, I suppose, because there are few who think a man can understand medicine and surgery by instinct. But, till the last 10-20 years, people in England thought every woman was a Nurse by instinct (1859, in Seymer 1954, p274).

Virginia Henderson

Virginia Henderson, an American nurse and academic, notes that Nightingale's concept of nursing, one of *enabling nature* to heal the patient, has probably not been bettered. Henderson's definition of nursing builds on that of Nightingale in that it also recognises that the process of nursing should be (although often is not) focussed upon the promotion of healing and health, rather than on the medical model of 'cure'. Henderson's definition was that adopted by the International Council of Nurses in 1960 and is still widely used. Henderson describes the role of the nurse as:

> To assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to a peaceful death) that he would perform unaided if he had the necessary strength, will or knowledge. And to do this in such a way as to help him gain independence as rapidly as possible...This aspect of her work, this part of her function, she initiates and controls; of this she is master (Henderson 1991, p21).

In conjunction with the above, Henderson adds that nursing also involved delivering the treatment plan prescribed by the doctor, and working with others in the therapeutic team.

Despite the need to work with others, Henderson regards the nursing role as unique however, claiming:

> There are few more difficult arts than that of keeping a patient well nourished and his mouth healthy during a long comatose period, or that of helping a depressed, mute, psychotic individual establish normal human relations. No worker but the nurse can and will devote himself or herself consistently day and night to these ends. In fact, of all medical services nursing is the only one that might be called continuous (1991, p23).

This role, it must be argued, cannot be carried out by someone relying on 'instinct' or 'common sense' with only a basic knowledge of anatomy and physiology. Henderson also notes that the nurse has "...an infinite need..." (p23) for skills and knowledge derived from the social and biological sciences. In this, she again builds on Nightingale's assertion (see chapter 1) that a nurse is someone who should be able to apply knowledge in their work, and that it was the intelligent application of such knowledge which comprised wisdom and enabled their vocation.

The Royal College of Nursing

The Royal College of Nursing (RCN) has published what it terms, a 'policy statement' - *Defining Nursing*, with the stated aim of providing nurses with a means of describing what the process of nursing is and what its objectives are (Royal College of Nursing 2003). By implication, the ability to show what is specifically different about nursing from, for example, any of the other 'therapies', or even medicine, should enable nurses to answer the question, 'what is a nurse?' I think it is important to note that the definitions of nursing produced by the RCN in this publication were formulated after consultation with nurses themselves, both in the United Kingdom and abroad, and

including all members of the International Council of Nurses. The RCN states that it envisages this information should be used by nurses and others in decision making at all levels, including the influencing of policy making at governmental level and perhaps at the level of determining staffing numbers and skill mix in hospital or community nursing teams. This latter is particularly pertinent at the present time when NHS trusts are increasingly relying on the introduction of unqualified health care assistants to provide 'nursing' care (Department of Health 2005). In fact the RCN is quite clear on the contribution of 'informal' carers, including relatives, support workers and care assistants - it is 'invaluable', but also notes that their contribution "... is different from that of the professional nurse" (2003, p4). It is not, according to the RCN, the differences in the tasks undertaken, or even the level of skill required to perform them, which distinguishes informal or unqualified 'carers' from the nurse. Rather, it is the possession and the exercising of *clinical judgement* when assessing, diagnosing and planning nursing care. The RCN also cites the possession of *knowledge* required to carry out the above, personal accountability for nursing actions including delegation of tasks, and professional regulation within an ethical and statutory framework, as also contributing to this distinction. Other than the requirement of professional registration and regulation, Nightingale would probably find little to disagree with the RCN here.

The RCN's definition of nursing comprises a core statement supported by six defining characteristics.

Core statement - Nursing is:

> The use of clinical judgement in the provision of care to enable people to improve, maintain, or recover health, to cope with health problems, and to achieve the best possible quality of life, whatever their disease or disability, until death (2003, p3).

The RCN's six defining characteristics are headed (i) 'particular purpose'; (ii) 'particular mode of intervention'; (iii) 'particular domain'; (iv) 'particular focus'; (v) 'particular value base'; and (vi), 'commitment to partnership'. It stresses that the *uniqueness* of nursing is expressed through the *combination* of these characteristics, as other health care workers may also share some of them to a greater or lesser extent. This claim is examined below.

(i) The *particular purpose* of nursing is the "...promotion of health, healing, growth and development, and to prevent disease..." (p3). It is also to help people cope with illness and alleviate suffering even where death is the inevitable result. This *purpose*, of course, could also be that of medicine. The combination of this purpose with the second should further refine the definition.

(ii) The RCN claim that nurses (*in particular*), *intervene in human activity* with the aim of empowering patients so they may regain their independence and that they do this through an "...intellectual, physical, emotional and moral process..."(p3). (The need for knowledge, including moral and spiritual knowledge is evident here). This process informs and enables the identification of need, the implementation of the intervention, personal care, education and emotional and spiritual support. The concept of empowerment and rehabilitation is a relatively recent expressed aim of nursing and, as noted in chapter 1, has met with some resistance from those who may confuse a refusal to lift a patient in or out of bed (in favour of teaching them techniques for doing it themselves) as uncaring, rather than as a method of rehabilitation. The RCN also include under this 'heading', teaching, management, and the development of knowledge and policy - activities which could also be purposes of any other health care profession.

(iii) The particular domain of nursing is, according to the RCN, the unique responses of people to "...health, illness, frailty, disability..." (p3) and other health related events. These responses could be "...physiological, psychological, social, cultural or spiritual, and are often a combination of all of these. The term 'people' includes individuals of all ages, families and communities, throughout the entire life span" (p3). This characteristic appears to be an attempt at bringing together the different branches of nursing, those of general adult nursing, child nursing, mental health nursing and learning disabilities nursing. It would also appear to encompass health visiting and community nursing. Again however, it is difficult to ascertain why the above should apply any less to medical doctors, who also address the unique responses of individuals within the different branches of that profession.

(iv) The fourth characteristic of nursing is that of having a *particular focus* on the patient as *a whole person* in tandem with that person's unique response to illness. In this it shares much with the previous characteristic, that of the domain of nursing, which also addresses patient responses. Here however it could be claimed that other professionals have their focus on patient responses to a particular *aspect* of that person, e.g. his mental health, or a disease of her heart or kidney, or perhaps the fact he is homeless. For myself, it is perhaps in this aspect more than any of the other characteristics proposed by the RCN, that the unique characteristic of nursing is expressed. For example, in the case of a patient admitted to hospital for an operation to have a kidney removed, a renal surgeon will have diagnosed (a defective kidney) and recommended the treatment (removal) and will carry it out. An anaesthetist will have examined the patient's lungs and ability to withstand an anaesthetic. A physiotherapist may teach the patient breathing exercises to prevent chest infection. A dietician may be needed to advise on a special diet after the operation. However, it is the nurse who will physically and importantly, emotionally remain with the patient before, during and after these personnel have intervened. It is the nurse who will be

responsible for monitoring and enabling the patient to carry out their instructions. It may be that the patient is unable to understand, due to sensory disablement, or dementia, or may have difficulty eating due to oral disease or the fact they need dental care. Some may be anxious and afraid of dying. It is the nurse who has the responsibility for ascertaining the patient's social circumstances - who will care for them on discharge? Is their accommodation suitable? Do any adaptations need to be made and to whom should referrals be made? One diseased kidney may be very much like another, but each patient with the same disease is very different when approached *holistically*, and the nurse is the only professional who is left to address those differences through focussing on the *whole person* rather than on one aspect of them.

(v) and (vi) The final two characteristics of nursing proposed by the RCN state that nursing has a *particular value base* (v), incorporating ethical values and personal accountability underpinned by legislation and the system of professional regulation by the Nursing and Midwifery Council (NMC). Characteristic (vi) a *commitment to partnership,* states that nurses work "...in partnership with patients, their relatives and other carers, and in collaboration with others as members of a multi disciplinary team" (p3). They also delegate and supervise others and are also at times led by others but "...at all times, however, they remain personally and professionally accountable for their own decisions and actions" (p30). My criticism in relation to these final two characteristics is that I do not believe they are in any way *specific to nursing* but could apply to many other health care professions, including the therapies (physiotherapy, occupational therapy, speech therapy etc) and to medicine, the members of which also work in partnership, within a code of conduct, to ethical principles, and indeed within the health care team.

If the RCN's definition of nursing, and thereby by implication, *nurses*, is open to criticism in relation to distinguishing nursing work from that of other professionals (even when the above six characteristics are conceived as a whole), it is arguably more successful when used to distinguish professional, i.e. *registered* nurses, from informal, untrained carers. The RCN claims, in its 2003 document, that its definition of nursing should help nurses explain to employers and the public what they should expect from a trained nurse in terms of what they might be expected to carry out, and also in terms of impact on patient welfare. In respect of the latter, research has shown that the ratio of registered nurses to unqualified carers in a workforce has a direct effect on patient recovery times, complication and mortality rates (Needleman et al (2002). The issue of nurses undertaking work previously performed by doctors is also addressed in the report. In fact the RCN, having identified that many definitions of 'advanced' and 'specialist' practice originate outside the United Kingdom, particularly from the United States, is now developing an educational "...framework for post-registration education and practice in nursing specialities. The newly formed Faculty of Emergency Nursing has developed and piloted a core competency framework, covering different levels of practice" (2003, p22).

Importantly, the RCN stresses that without a working definition of nursing at both a generalist, specialist and advanced practitioner level "...media – based stereotypes and managerial specifications will fill the vacuum" (2003, p5). The implications of a general acceptance (and particularly an acceptance by NHS consortia who purchase nurse education) of the majority of media representations of nurses and nursing, illustrated above, has profound implications for the development of nurse education.

3.3 The views of policy makers

The following reports have been selected for discussion as they have either been commissioned and published by a professional body, the United Kingdom Central

Council for Nursing and Midwifery (The forerunner of the NMC), *Fitness for Practice* (UKCC 1999), or by the Department of Health, *Making a Difference* (Department of Health 1999), *Liberating the Talents* – Helping Primary Care Trusts and nurses deliver the NHS Plan (Department of Health 2002), and *Modern Matrons* (Department of Health 2003). *Fitness for Practice* (the Peach Report), as has also been noted in chapter 1, reports on perceived deficiencies in the practical knowledge and skills exhibited by newly qualified nurses who undertook their training in universities under what was known as 'Project 2000'. The foci of the Department of Health papers are very much on the nursing and midwifery contribution to NHS reforms and as such, illustrate government thinking on new roles for nursing and implications for education.

Fitness for Practice (UKCC 1999)

Although the report recommends far-reaching reforms to nurse education which, as its title suggests, would render newly qualified nurses 'fit for practice' (and which will be discussed further in chapter 4), it surprisingly shies away from producing a definition of what that practice might consist, noting "...a definition of nursing would be too restrictive for the profession" (1999, para 2.19), the reason given (paradoxically) being the rapidly changing nature of the role. However, it does cite Henderson's (1961) definition referred to at page 114 of this thesis which, as I noted, builds on that of Nightingale herself.

The issue of the level and type of knowledge required by nurses is addressed tangentially, i.e. a recommendation that the problem of fewer younger people from whom to draw recruits to the profession should lead to more flexible routes into nursing courses, and the modification of existing courses "...to accommodate recruits with different types of prior experience and knowledge, and to prepare all students to meet the real demands of practice at the point of registration and beyond" (1999, Para 3.2). What the Report is suggesting is that students with fewer and lower level

academic qualifications should be admitted, and this is indeed what is increasingly happening. Unfortunately the paradox is, as it goes on to say, that degree level programmes are much more popular than diploma level pre-registration programmes even though they do not attract financial support in the form of a bursary which diploma students receive. One answer is apparently to attract students from ethnic minority groups, which would also have the consequence of the nursing workforce reflecting more accurately the population of local communities and the population in general. Interestingly, the issue of attracting more highly qualified men into the profession (a far larger sector of the population), which would also have the effect of better representing the general population, is never mentioned. Nurses, for this Report are assumed, in the absence of any evidence to the contrary, to be female.

The image of nursing as a career choice is examined - the media being blamed for portraying nurses as overworked and underpaid. Recruitment problems are also blamed on low minimum entrance qualifications - five GCSEs or equivalent for diploma courses. The Report claims that young people with these qualifications are more likely to study for A levels and then for a degree rather than opt for a pre-registration diploma course. Again, the contradiction is evident between this claim and that made elsewhere in the same report, that more flexible, in effect 'lower', entrance qualifications should be considered to increase recruitment. Should the nurse of the future be highly educated, as changing and more complex roles might suggest, or should educational expectations be lowered to attract greater numbers of (apparently) female students? *Fitness for Practice* seems unable to resolve the paradox.

Making a Difference (Department of Health 1999)

This paper states the Government's proposals for the nursing and midwifery contributions to Health Service reforms. It envisages an increased role for nurses

particularly in primary care - the Government "...wants to see more nurse-led primary care services to improve accessibility and responsiveness" (1999, p2). Nurses and midwives are also told to take a more fundamental role in the formulation of national service frameworks setting out the care requirements for children, older people, and a series of chronic diseases, such as heart disease and cancer. The proposals envisage enhanced leadership of health care teams by nurses and health visitors and lay the foundations for the development of consultant nurse positions. Frank Dobson, the then Secretary of State for Health, set out his concept of nurses and nursing in the Foreword to this document "Modern nursing, midwifery and health visiting is not just a matter of personal attention and tender loving care. Their jobs now require the operation of new high tech equipment and the application of new clinical techniques and new pharmaceutical products". The tension between the Government's vision of a role for nurses and the recommendation in *Fitness For Practice,* that there should be a wider entry gate for admission to courses which *may* arguably result in candidates with less of the academic potential needed to achieve these aims, is evident.

Liberating the Talents (Department of Health 2002)

This is a guide for Primary Care Trusts containing examples of good, innovative practice sourced throughout the country on how best to carry the NHS Plan forward. It builds on the previous paper, *Making a Difference,* and provides a strategic framework for those professionals in order they might participate fully in the aims of the NHS Plan (Department of Health 2000). The Government's NHS Plan summary paper describes the Plan as one for investment and reform with the aim of delivering a patient need led NHS fit for the 21st century. The paper claims:

> *For the first time* nurses and other staff, not just in some places but everywhere, will have greater opportunity to extend their roles. By 2004 over half of them will be able to supply medicines. £280 million is being set aside over the next three years to develop the skills of staff (2002, p6).

And:

> The number of nurse consultants will increase to 1,000...A new Leadership Centre will be set up to develop a new generation of managerial clinical leaders, including modern matrons with authority to get basics right on the wards (p6).

Liberating the Talents sets out 10 key roles for 'appropriately qualified' nurses, midwives and health visitors which it requires NHS employers to actively promote, and which should arguably radically change the way in which the public (through personal experience), and also hopefully the media, will conceive of nurses. These key roles are:

> (i) To order diagnostic investigations such as pathology test and x-rays.
> (ii) To make and receive referrals direct, say, to a therapist or pain consultants.
> (iii) To admit and discharge patients for specified conditions and within agreed protocols.
> (iv) To manage patient caseloads, say for diabetes or rheumatology.
> (v) To run clinics, say, for ophthalmology or dermatology.
> (vi) To prescribe medicines and treatments.
> (vii) To carry out a wide range of resuscitation procedures including defibrillation.
> (viii) To perform minor surgery and outpatient procedures.
> (ix) To triage patients using the latest IT to the most appropriate.
> (x) To take the lead in the way local health services are organised and the way they are run (2002, p7).

Importantly, this paper also argues that better care for patients can be secured through giving nurses "... a much greater freedom to innovate and make decisions about services and the care they provide" (p10).

In addition, the paper contains quotations from patients which give some indication of their conception of the role of the nurse in their lives. For example, "Having a nurse is important. You get everything in one person" and "I feel more comfortable talking to the nurses, they have more time and explain things clearly".

Modern Matrons – Improving the Patient Experience (Department of Health 2003)

Modern Matrons are sited at a level above that of the ward sister or charge nurse and may oversee several wards from a particular speciality such as 'general' surgery, urology, ophthalmology etc. The role was introduced in 2001 with a remit to *inter alia,* provide leadership, governance and innovation to improve the patient experience. This (2003) paper contains examples of innovative practice initiated by matrons throughout the NHS in line with the key roles envisaged above in *Liberating the Talents* (Department of Health 2002). The Report notes that many of the new roles have already been implemented:

> It is clear that it is now common practice, for example, for many nurses to request tests and investigations, make and receive referrals, run clinics and carry out outpatient procedures. There are good examples of nurses admitting and discharging patients, holding their own caseloads and taking the lead in the way local health services are run (p6).

One initiative illustrated in the Report involved reducing patient waiting times. Another was aimed at reducing patient complaints through increasing the skills and knowledge of nurses working in a particular department so they were able to order and carry out ECG tests on patients arriving with chest pain and who may have been suffering from a heart attack.

In order for the Government's plans for the NHS to come to fruition, it has in its own policy documents admitted a need for an increase in the number of nurses who have a high level of academic and practical skill and judgement. The contrast with media images of the nurse as 'witch', 'angel' and 'housewife' or 'sex object', could not be more vivid.

3.4 Conclusion

It should be clear that the views of policy makers and the RCN at least, seem to point to a future of a higher, more technical, strategic role for registered nurses. This has

profound implication for nurse education. More so than in the images of nurses found in the media, there is in the policy documents a clear view of the type and level of knowledge required by both the present day and future nurse. What I would argue is missing however from these papers, and even from the definitions of nursing produced by nurses (including that of the RCN), is Nightingale's insistence on the moral and spiritual dimension of knowledge. This aspect of knowledge and its place in nurse education will be revisited in the final chapter of this thesis.

In her introduction to *Modern Matrons – Improving the Patient Experience* (Department of Health 2003), Beverley Malone, the then General Secretary of the RCN, said "Quality care depends on having an educated, motivated and valued workforce". However, as *Fitness for Practice* (UKCC 1999) illustrates, there is a tension between the need for highly educated personnel with both theoretical and practical skills who can operate at degree level and beyond, and the need for greater numbers of nurses drawn from a shrinking pool of young women. Arguably, nurses should heed the words of the patient cited in *Liberating the Talents* - "Nurses need to tell the public what they can do these days", otherwise the more pervasive images of nurses emptying bedpans and smoothing fevered brows will remain in the public's consciousness, and impact negatively on attempts to meet the needs of present day patients through educational reform.

Chapter 4: Re-appraisal

Introduction

Chapter one of this thesis traced a history of the development of healing practices prior to, during and after Nightingale's 'invention' of modern nursing. It analysed that history in terms of the knowledge base required at differing times, and utilised language denoting three different 'types' of knowledge, that of theoretical, practical and moral and spiritual knowledge. It was noted that the importance given to each of these three 'types' of knowledge in the training and education of practitioners varied over time. I noted that prior to the Enlightenment there was a heavy reliance on moral and spiritual knowledge as there was a dearth of awareness of the physiology of the human body and therefore the causes and effect of disease process. I also stressed the separation of healers educated and trained in different spheres, i.e. on the one hand the university educated 'physicians' and on the other, the 'lay' healers. The latter, mainly women, as Ehrenreich and English (1973) argued, probably had a higher level of both theoretical and practical knowledge and skills than the former, their male 'doctor' counterparts who relied on 'theory' learned in the universities. Conflict between the university educated 'doctors' and what became eventually to be the residual occupation for women, that of nurses in the Nightingale mould, continued during and after Nightingale's reforms with arguments over how much 'theory' nurses required and the dangers of 'overeducating' them.

I have also noted that the third form of knowledge, moral and spiritual, appears to have been of historically decreasing importance in the minds of both the writers of those nursing texts analysed, and the media perhaps since the 1960s. I have also argued, particularly in chapter 3, that although government White Papers and descriptions of 'nursing' written by nurses themselves are only too able to create lists

of nursing tasks and duties which appear to be ever-expanding and requiring of greater knowledge, both theoretical and practical, a notable absence appears to be that of any reference to a requirement for a moral and spiritual dimension to nursing practice.

In addition, Chapter 3 has demonstrated that currently the concept of *what* and at *what level* a nurse needs to know is somewhat out of kilter with some media images, at least according to the policy documents emanating from the Department of Health. Nurses now and in the future would appear to need forms and levels of knowledge which seem to go beyond that which has been described as 'practical knowledge' or knowledge *ready to hand* (Heidegger 1962), although such knowledge does remain important for some, but not all nurses, depending on their area of practice.

I intend in this, my final chapter, to examine whether the perceived distinctions between the three major classes of knowledge (theory, practice and moral and spiritual) upon which nursing education has, and remains founded and argued over, are in fact tenable and what, if any, implications my conclusion may have for nurse education. The issue is an important one as the system of nurse education, that of providing access, instruction and assessment in 'theoretical' knowledge in the university setting, and 'practical' knowledge and skills in clinical placements remains accepted practice throughout the United Kingdom, despite expressed problems in relation to the integration of these two 'forms' of knowledge and the pressure on clinical areas to provide adequate learning experiences where students may gain their 'practical' knowledge.

4.1 The (uneasy) relationship between 'theory' and 'practice' in nursing education

Celia Davies (1980), as noted in chapter 1, has argued that the system of nurse training in existence from the time of Nightingale's reforms until, in principle at least, the advent of Project 2000 in the 1980s, had a rationale which was at best arbitrary and at worst a means to staff hospitals with cheap labour. Despite the contribution of numerous reports produced during the nineteenth and twentieth centuries (see chapter 1) on the subject of *what* nurses need to know and *how best* to teach that knowledge, I would argue that the system of educating nurses we have in 2007 still appears to be a legacy of the Nightingale apprenticeship system with its reliance on the acceptance of the existence of sharply delineated forms of knowledge, theoretical or propositional knowledge and practical knowledge which may be assumed to be taught in either a classroom or in clinical practice respectively. The very terminology attached to the system of training introduced by Nightingale, the 'apprenticeship' system, implies an emphasis on a practically based training, the emphasis on knowing 'how' rather than knowing 'what', although Nightingale herself argued for the teaching of 'theory' too. As has been demonstrated earlier, this assumption seems to be firmly implanted in the minds of educators and policy makers. The battle for ascendancy between 'theory' and 'practice' continues to the present day as the criticisms of Project 2000, and the subsequent retreat from what was considered to be an overly theoretical curriculum recommended by the Peach Report, Fitness for Practice, (UKCC 1999) demonstrate. In addition, the remit of the Report was to also address the issue of somehow 'integrating' theory and practice. Despite however the overwhelming burden of historical and contemporary pressure to acknowledge that 'knowledge' can, and indeed should be categorised in such a manner, there appear to be some who are prepared to challenge the assumption that there are two fundamentally different bodies of knowledge which are somehow at odds with each other and require, particularly in vocational education, to be reconciled and integrated

in order to produce a nurse 'fit for practice'. Before these ideas are examined at length however, an insight into the extent of the influence of the perceived divide between the two apparent types of knowledge is detailed below.

Conflict appears to have been in evidence at least since Nightingale's mid-nineteenth century reforms as related in detail in chapter 1. In addition, a particular participant's views on the matter can be seen to be largely dependent on the social context and position from which they were writing.

For example, Nightingale's efforts to reform nursing and make it attractive to middle class secular women required her to insist on an *intelligent obedience* and a sense of vocation (1.3). And interestingly, Nightingale's attitudes to outward manifestations of knowledge (when speaking of examinations) appear similar to that of Gerard Lum (2007, see below), in that she disparages the use of such measures to gauge the possession of knowledge. She implies the ability to pass examinations may mask the fact there is nothing inside that person, who may not be a 'Nurse Nursing' but merely a 'Nurse' reading a book on Nursing (1.4, p23).

Doctors also have their opinion on what nurses might require in order to be professionally capable. Historically, the division of healers into male university educated physicians and mainly female ('uneducated' in academic terms) 'wise women', 'witches' and 'midwives', has been described, as has their successor, the 'bad style of nurse' resulting from too much 'theoretical' knowledge noted by the British Medical Journal (Anon 1897) (at 1.3, p19). In 1932, The Lancet Commission on Nursing (see 1.5, p26) also recommended that some 'theoretical' knowledge be removed from the nursing syllabus, the Commission's perspective on the preparation/performance gap being clouded perhaps by professional rivalry and worries about loss of 'control'?

In addition, the battles between the hospital matron-dominated General Nursing Council and those in the Royal College of Nursing who wished to reform the apprenticeship system of training during the 1960s (1.6) centred on what sort of nurse the hospital service wished to see, one with 'practical knowledge' who could be easily socialised and therefore controlled (and preferably therefore with employee status throughout their training), rather than one 'professionalised' through a more academic, 'theoretical' education under the influence of higher education institutions. Even the research informing the Peach Report's recommendations noted that although a practical skills deficit was apparent in newly qualified Project 2000 nurses, this was quickly addressed within a few months of practice. It also found managers appreciated the analytical skills of Project 2000 and their questioning approach. (ENB 1996). Unfortunately, such an appreciation was not sufficient to halt the managers' call for more practical knowledge and less theory in the students' curriculum. As students were no longer regarded as employees (at least in theory), greater numbers of healthcare assistants have been needed to replace student nurse labour. Hence, perhaps the disadvantages in terms of reduced staff numbers brought about by the supernumerary status (as remains the case at present) of Project 2000 students may have outweighed the advantages of a more analytical and enquiring staff provided for these managers.

Images of nurses in the media have further complicated the issue. The general public could be excused for believing that nurses require very little in the way of 'practical' or 'theoretical' knowledge, rather they are acting out the traditionally female roles of 'witch', 'angel', 'housewife and mother', or 'sex object', for which performances one requires very little more than life experience. As chapter 3 illustrates, some journalists have also colluded in and indeed promoted this view, utilising the division of knowledge into 'theory' and 'practice' to argue that nurses are receiving too much of one type and not enough of the other. Liam Clarke (2004) who, as described later in

this chapter, advocates the movement of at least general nursing back to hospital-based centres of learning, has argued that, in relation to Project 2000, "The backlash was not long in coming, particularly from certain sections of the right-wing press who were vitriolic in condemning what they saw as the corruption of nursing by academia" (p40). He goes on to say that, "The rush to get nurses back to the bedside, the re-emergence of matron, the constant bickering about hygiene and nurses refusing to do 'the basics' are essentially anti-women tirades borne of dismay at nurses presuming to conceive their work as not merely common sense" (p40). Christine Hancock, the President of the Royal College of Nursing, crystallised the issue when she spoke against the notion promoted by the media and others, that education (held to be mainly 'theoretical knowledge) and practical skills are mutually exclusive (see 1.7, p44).

As Gerard Lum (2007) notes, this 'battle' has been, and continues to be, unhelpful in informing any debate on the optimal manner nurses may be educated or trained to be 'fit for practice'. In addition, the response to criticisms of an over-theoretical curriculum levelled at Project 2000, the Peach Report, Fitness for Practice (UKCC 1999), merely tried to strike another 'balance' between 'theory' and 'practice' arguing for a greater emphasis on 'practical skills'. The Report notes in its introduction that:

> Newly-qualified nurses and midwives who have undertaken the current diploma or degree level pre-registration programmes are found to posses many positive qualities – a good theory and knowledge base, research awareness, communication skills and insight into their personal limitations – which are all regarded as highly desirable attributes by employers (UKCC 1999, para.4.1, p34).

One might think the above represents a resounding affirmation of the success of Project 2000. However, the Peach Report goes on to say in the following paragraph that "There is disturbing anecdotal and empirical evidence indicating that newly qualified nurses and midwives have a need for constant support and may lack

practical skills literacy" (1999, para.4.2, p34). Of course, such evidence may only reflect *expectations* of what a newly registered nurse should be able to do, based on existing practitioners' personal position and past experiences of the same. Such expectations may be wholly or partly unreasonable given the rapidly changing nature of health care provision and the environments in which nurses are expected to work. This is something referred to by Sam Galbraith, the Scottish Health Minister, who is quoted in the Report as telling an RCN conference that he did not think it altogether reasonable that newly qualified nurses should be expected to have all the skills deemed necessary by NHS managers on registration, and he compared these expectations to those applied of newly qualified doctors who then spend a year as a House Officer acquiring theirs. As the Report states, the UKCC (now the Nursing and Midwifery Council), only requires students to be 'fit for practice' at the point of registration. It attempts to distinguish, not altogether successfully, between 'fitness for practice' required by the professional regulatory bodies and 'fitness for purpose' required by prospective employers:

> The UKCC is primarily concerned about fitness for practice – can the student register as a practitioner? The assessment of fitness for practice depends on the scope and nature of practice and how this evolves over time – on an individual level, as careers progress, and on a societal level, as health care needs change. Registration, thus, represents an endorsement of the individual's fitness for practice... (1999, para.4.4, p34).

However:

> Prospective employers are primarily concerned about fitness for purpose – is the newly qualified nurse or midwife able to function competently in clinical practice? The speed of change in the context and content of health care makes it difficult to define fitness for purpose – its meaning cannot be fixed...Given the pace of change, it seems unreasonable to expect fitness for purpose – other than in the broadest sense – to be a function of pre-registration education (1999, para.4.5, p34).

This last sentence is an interesting admission and seems at odds to some degree with the Report's remit to produce recommendations for reform of training to address the

apparently anecdotal and empirical evidence that newly qualified nurses, "...need constant support and may lack practical skills literacy" (1999, para.4.1, see above).

The preceding excerpts from the 1999 Report also reinforce Lum's (2007) argument that what is under discussion here, and throughout the literature focussing on vocational education and training, is not perhaps two forms of knowledge but the adequacy of 'preparation for performance'. Closer reading of the Report reveals further inconsistencies in the use of terminology. For example, Peach writes of 'theory and practice components of pre-registration programmes (para.4.14, p36) in terms of 'outcomes' which should 'cover' these components. It is, however, important to get the balance between these components right according to the Report. Is it performativity which is being discussed and described here, or is an increase in weight to be given to a particular 'type' of knowledge being advocated? The Report noted that an attitudinal survey showed:

> 59 per cent of recent registrants believed that more practice and less theory was required in the first year of their programmes. Only 29 per cent of experienced staff in contact with Project 2000 nurses considered them to be very/quite well prepared in terms of essential practical nursing skills. In contrast, 84 per cent of experienced staff believed that Project 2000 nurses were very/quite well prepared in terms of understanding nursing theory (1999, para.4.3, p39).

There are two major conclusions which could be drawn from these results. One is that somehow the new registrants did not feel fully prepared for life as a registered nurse, in which case the question has to be *why* they thought the deficiency in preparation, i.e. more 'practice' and less 'theory', should be addressed in their *first* year of training, in contrast to perhaps, their last year. Had they acquired anti-academic attitudes from more experienced staff during their training? As chapter 1 of this thesis illustrates, these attitudes have been documented throughout the history of nurse education. Or were these views based on reasonable evidence and argument? The report does not give any further details other than the registrants 'believed' this to be the case.

Another conclusion the Report could have reached paradoxically is that less 'theory' should not be countenanced as 84 per cent of experienced staff thought new registrants were well prepared in terms of understanding such knowledge. Reducing the amount of theory would presumably compromise that level of understanding and must surely be unacceptable.

The Peach Report also includes a quote from a theatre sister which illustrates the problem of deciphering 'what' it is that nurses appear to be so concerned that they are lacking - preparation for performance or a discrete form of 'practical' knowledge, or something else? The sister is quoted as saying, "More clinical experience is required pre-registration than is currently being provided..." (1999, para.4.29, p39). This appears to be a plea for new registrants to be fit for purpose through being exposed to the clinical environment perhaps in order to familiarise themselves with it, or perhaps to 'learn new skills', for example how to prepare a patient for theatre. We do not know the details from the information given. However, she continues "... there appears to be an over-emphasis on the academic area at the expense of clinical experience. A good nurse should be able to use her hands as well as her brain" (p39). Is the sister alluding to fundamentally different types of knowledge required by a nurse? She is certainly alluding to the presence of the 'gap' between an ability to 'know that' and 'know how,' and, through the use of terms such as 'over-emphasis', is surely inferring that there is a battle on for ascendancy between the two and that the 'know that' camp is winning. Her argument that an ability to use hands and brain is necessary would seem to be incontrovertible, but the inference in her statement read as a whole appears to be that she would rather see *less* academic or 'theoretical' input and more 'practical knowledge or skill' perhaps gained through more clinical experience. Is more 'hands' and less 'brain' really what is wanted from a nurse assisting a surgeon in an operation, particularly when complications occur? Would the same reasoning, i.e. that somehow the delivery of one 'type' of knowledge be reduced in favour of a greater

emphasis on another, be applied to a surgeon for example? Or, rather would it more likely to be accepted that the education of a surgeon required a large amount of both academic *and* clinical experience to be fit for 'purpose' and 'practice'?

Liam Clarke (2004) throws some light on why it may be that so many *nurses* appear to question the value of 'theory' to their practice, and by inference reinforce and perpetuate the notion that the two represent different 'types' of knowledge which are in someway at odds with each other. Clarke himself is sceptical of the siting of pre-registration education in the university and argues for a shortened, 'practical' training of two years for 'general' nurses outside the university setting. (He does not advocate the same for mental health nurses or children's nurses). He continues, "For those wishing to go beyond basic training, universities can provide higher courses" (p41). What Clarke appears to be advocating is a return to the position of the enrolled nurse, introduced to alleviate the nursing shortage after the second world war. A two year training consisting of less 'theoretical' knowledge was introduced with the aim of attracting those without conventional academic entrance requirements. The enrolled nurse worked under the direction of the registered nurse and undertook more 'bedside' care, leaving the registered nurse to manage the ward and the ward team. Enrolled nurse training was abandoned prior to the advent of Project 2000, the role largely filled now by a variety of health care assistants with National Vocational Qualifications at various levels, although possession of these is not mandatory and is at the discretion of employers (Cockayne et al 2007).

Clarke's argument is that students' have *prior perceptions* of nursing and of their role as nurses in the health care team. This perception is that of an essentially practical occupation and that they have very definite ideas of *what* they want to learn.

He notes:

> Many students are already socialised into an occupational mindset, which they bring to their student role. No doubt augmented by their employment in nursing homes or in the NHS via agencies, this mindset significantly influences what they want to learn. When on student placements, they find out what 'works' and quickly deduce which parts of the curriculum are irrelevant to practice (2004, p39).

Even if student nurses have not been socialised in such a manner as Clarke suggests through prior employment, chapter 3 of this thesis has argued that in general, the media has persistently downplayed the need for nurses to acquire any 'type' of knowledge other than perhaps the ability to smooth sheets or mop fevered brows. This mismatch between images of the nurse in the media and that of an increasingly important health care provider may have not only affected the perceptions of the general public and policy makers but even those of potential nurses themselves.

The overall result of these influences is, according to Clarke, a perception that nursing is essentially practical and that 'theoretical knowledge' other than perhaps anatomy and physiology is superfluous. 'Theory' and 'practice' are again seen as different entities, not only by students but apparently also by writers such as Clarke himself who uses terms such as 'academic' without explanation or qualification, as in:

> ...nursing students becoming ensnared by the requisites of practice is extremely problematic. Ensnared may be too easy: a truer picture is that they arrive already convinced that nursing is a practical undertaking only to find a curriculum whose assumptions are primarily academic (2004, p39).

And also, tellingly, in relation to medicine and law, "My guess is that many members of these professions would prefer the practical aspects of the job rather than its theory" (p39). It is a moot point whether doctors and lawyers would, or even could, demarcate their occupations in such a way, i.e. into theoretical and practical aspects. I would guess they might argue that such distinctions are irrelevant, and in any event

what others might personally 'prefer' is entirely another issue to that which these professions might see as *essential* in order to function.

Tellingly, Clarke (a lecturer in mental health nursing), argues that the perception of nursing as 'practical' (and therefore only requiring 'practical' knowledge) is only the preserve of those training as general nurses for the 'adult' branch of the nursing register. These nurses make up the vast majority of registered nurses and work with those patients with physical illness or frailty and who therefore might require surgery or treatment with medication for their physical disabilities. They do not work with patients who are suffering solely from a mental illness - the preserve of mental health nurses. In addition, Clarke notes that all these (general) nurses require is to be able to, "...work effectively in treatment settings" (p41). After all, he queries, "How much theory do you need to administer an injection – a practical skill honed by experience?" (p39). He uses the term 'basic level' to describe the ability to work effectively in clinical areas. He also argues that university courses should only be available to those who wish to aspire to a higher level of practice, although he does not define what that 'higher level' might be. Clarke claims however, that with regard to students training to become nurses working with people with mental illness they are:

> ...more susceptible to the types and levels of debate that are appropriate to a university...they are concerned with issues that often transcend medicine. Mental health branch programmes may resemble psychology courses more than nursing courses (2004, p39).

Mental health students by Clarke's reasoning therefore require more 'theoretical' knowledge. What Clarke is actually criticising here is the inclusion of subjects such as sociology and psychology in general nurse training courses. He admits the need for anatomy and physiology and claims students do too. It is interesting to note that anatomy and physiology are not apparently viewed as 'theory' in quite the same manner as psychology for instance. This anomaly calls into question whether Clarke

is arguing for less theoretical knowledge or merely less knowledge of psychology and sociology. Of further concern is his claim that "Pre-registration adult branch nurses seek descriptive curricula, watered down versions of medicine, and they generally resent being denied this" (p40). This statement begs the question, what actually is being watered down here – theoretical or practical (medical) knowledge? Perhaps, as Clarke has earlier claimed, that doctors' need for *analytical* and *deductive* skills are a necessary component of medicine, he means *those* 'theoretical' skills (but, if carried out in clinical settings in relation to 'real' patients are they *actually,* practical skills?). Or, is he really claiming that nurses even at his 'basic' level do not need these abilities? Even a 'basic' level of nurse in Clarke's terms would surely need to be able to analyse and deduce the action to take when for example their patient presents with a slow pulse and a high blood pressure, or alternatively, a fast pulse and a low blood pressure? The possession of 'knowledge in the hands' alone will not help them in either of these scenarios, although 'knowledge in the hands' would help when the patient in question needed the insertion of an intravenous line or resuscitation after he or she stopped breathing or suffered a cardiac arrest. But then, so would knowledge of anatomy, and knowledge of the steps needed to carry out these procedures - theoretical knowledge. In effect, Clarke is, as are many others including the NMC (2004) and Peach (UKCC 1999), confusing and clouding the issue by describing apparent deficiencies in nurse education in terms of a 'gap' or an imbalance between 'theoretical' and 'practical' knowledge. Clarke is also writing from his own position and his vested interest in mental health, demonstrating the divisive nature of the issue within the profession. The terms used above to describe differing 'forms' of knowledge and the relationships between them can be seen to be at times ambiguous and problematical. The following section examines Peter Gallagher's critique of some forms of language commonly (but not exclusively) used in nursing education.

4.2 The problem of language

Indeed, there is an apparent lack of clarity and consistency in the use of terminology to describe theoretical knowledge - 'theory', 'propositional knowledge', 'knowing that', 'things present-to-hand' - not only by authors cited in this thesis but also by myself in related discussion and analysis throughout the same. Practical knowledge has been variously described as 'practice', 'knowing how', 'knowledge ready-to-hand', 'practical skills', 'bodily knowledge', 'knowledge in the hands', 'clinical skills', 'practical competency' and 'proficiencies'.

Another major hurdle for any criticism of an acceptance that there exist two (or three) discrete forms of knowledge as proposed, described and analysed throughout this thesis is the ubiquitous terminology currently employed to describe the relationship between them. Peter Gallagher (2004) critiques the concept of a 'gap' between 'theory' and 'practice', and has undertaken an extensive on-line literature search using the terms 'gap', 'theory' and 'practice' in the CINAHL database search engine. His literature search underlines the extent to which nurses in particular have accepted the inevitability of differing forms of knowledge and has signposted the problems generated for the profession by this demarcation. He notes that "...it was apparent that the language used to describe the relationship between theory and practice in nursing was reliant on spatial imagery" (2004, p 264).

He identifies four major categories of metaphor used in the literature to describe the consequences of an acceptance of the separation of theoretical and practical knowledge, practical knowledge being apparently subsumed into the concept of 'practice' itself as illustrated by the commonplace use of the duality 'theory and practice'. The first, relating to the 'gap' concept "... is that of the structural or building metaphor. Of this category the most widespread metaphor is the bridge or its derivations" (p264). He notes that references to "spanning" the gap are commonplace,

as are those which aim to "link" the two. If the 'gap' cannot be "linked" or "spanned" then it should be "filled". Interestingly, it would appear that his second category of metaphor "...is the dividing or splitting metaphor in which a sense of enforced and unnatural division is evoked: and the gap that has eventuated is a result of a split between the former component parts of a whole" (p264). This is evidenced through the use of words such as "schism", "rift", "chasm" and even "divorce".

Gallagher also notes that a third category of metaphors accepts the existence of two discrete forms of knowledge implicitly as the words used to describe the dichotomy is that of a failure to "blend" or "gel", and "heal". These categories of metaphor identified from the literature all imply that there is a fundamental difference between 'theory' and 'practical' knowledge and that this is undesirable - the use of the words '"schism" and "rift" are arguably used to denote an undesirable state of affairs. The metaphor of "healing" that separation would seem to reinforce this perception.

Finally, Gallagher finds in the literature that there is an argument that again accepts, as before, the 'gap' between theory and practice, but proposes ways in which the gap can be narrowed through the introduction and manipulation of educational strategies in the interests of producing a practitioner 'fit for practice'. He argues:

> The idea of a gap is ubiquitous and therefore silently pervades many aspects of nursing education and includes the design of courses with predetermined content, delivered over a prescribe time frame in a particular order by experts to students who rarely determine how they will address their own learning needs (2004, p265).

Gallagher also stresses that the 'gap' itself is no mere metaphor, but that:

> It must be emphasised that the gap is a construct, an explanation of a particular relationship and contrasts with the assertion that the gap has no physical presence. However, most conventional solutions for the integration of theory and practice are based upon tangible notions of manipulation...It is therefore not surprising that in an attempt to "solve the gap" educators have

> turned their attention to the external conditions in which the student learns (p267).

This is in my experience undoubtedly true, and rather than investigating philosophically the provenance and nature of the notion of this 'gap', *inter alia,* courses are designed as 'blocks' of clinical experience 'supported' by classroom teaching in an effort to minimise it. In addition, much effort is expended in encouraging students to provide evidence they have successfully 'bridged' the gap through 'integrating' 'theoretical' and 'practical' knowledge both in university and clinical settings. Indeed, forms of assessment in both areas will contain criteria which must be addressed or the student will risk failure. Such requirements may be the reciting of research evidence in a clinical context and conversely, reflection on a clinical experience in written assignments.

4.3 Theory and Practice – a re-appraisal

Gerard Lum (2007) also argues that the 'gap' (between theoretical and practical knowledge) is actually a tangible entity, noting that "The claim that the theory-practice gap is merely a metaphor is belied by the personal experience of a good many practitioners who can not only vouch for the existence of some such gap but can testify to its pernicious consequences" (2007, p131) some of which are noted above. However, Lum also argues that:

> Part of the problem here is a lack of clarity as to what exactly is meant by theory-practice gap, or more precisely, there is a tendency to conflate two very different meanings... To speak of a theory-practice gap is to draw attention to a perceived shortfall between training provision and the substantive knowledge requirements of an occupation; that is, a discrepancy between what is taught and what is actually needed in order to perform effectively in the workplace. Understood thus, theory-practice is roughly equivalent to 'training-work gap' or 'preparation-performance' gap (2007, p131).

Lum's argument that the long standing controversy over this 'gap' between 'theory and 'practice' can better (and more validly) be understood in terms of a 'preparation-performance' discrepancy is to be applauded here and for the following reasons.

As has been noted earlier in chapter 1, concerns expressed about the weight to be given to each 'type' of knowledge are longstanding, and on further analysis display a degree of muddled thinking about what is actually meant by 'theory' and, indeed, 'practical knowledge' – the ambiguity of language again. For example, a medical historian writing in the British Medical Journal (Anon 1897) argues that efficient nursing depends mainly on *skilful handling* and *observation* [my italics], (see 1.3, p19). One might argue that handling a patient could be learned, in Heideggerian terms, as knowledge 'ready-to-hand' (although if the patient declined to co-operate or complained of pain, one could argue for the need for knowledge, present-to-hand), but in the case of observation the author is surely not equating this activity with a purely 'practical skill'? The nurse must need to know 'what' and 'why' he or she is observing as well as 'how'. As Lum argues, the writer is *actually* discussing what he believes a nurse needs to know (preparation) in order to be an efficient nurse (performance). In the historian's opinion this does not include needing to know what he terms the intricacies of anatomy and physiology to the same degree as a medical student. However, importantly this is not the same as arguing that nurses were, and indeed are, being taught too much 'theory'.

Thinking of the 'gap' in terms of a discrepancy in the preparation and performance of nurses would also address the issue noted by Lum and (as he has described earlier), experienced personally by many practitioners including myself as a battle for ascendancy between the two 'forms' of knowledge. Lum argues cogently that theory and practice are not always seen by either practitioners or academics as *complementary* means to achieving 'fitness for practice' but as *competitive*,

"...ostensibly two alternative ways of achieving the end of effective performance" (2007, p132).

The first stage of Lum's thesis is then that the argument over the relative weighting to be given to each type of knowledge and the requirement to bridge the 'gap' between the two is at best unproductive and at worst destructive of the profession and of its educators. What is really meant is that the 'gap' (if one does exist), is that between preparation and performance. Lum then builds on this argument to show that in his view there is *no philosophical difference* between theoretical and practical knowledge. As I note in chapter 2, the concept of two forms of knowledge has a long history traceable to classical Greek thinking. Lum argues that historically we have all spoken in terms of two forms of knowledge, including, in Ryle's (1949) terminology, 'knowing how' and 'knowing that', to the extent that they have become "...grounded in the ordinary use of language ... [but this – DC] does not make it true that there are two kinds of knowledge..." (2007, p133). One commonly used argument supporting the notion that there are two discrete forms of knowledge is that:

> ...we can *see* plain instances of theory and practice, we can easily distinguish them, we can readily determine whether a person knows the theory or whether they know the practice of something; we *know* when we are teaching theory and when we are teaching practice, and so on. Observations such as these lie at the heart of our commitment to the theory-practice conception of knowledge (2007, p134).

As Lum states however, the terminology used in any discussion including that in the above quote is often vague and undefined. I would argue again that the problem is in our lax use of language and when we use terms such as 'theory' and 'practice' we are often merely using a 'scattergun' approach to describe concepts we have not really thought deeply enough about. Lum however has attempted to further analyse the terms 'theory' and 'practice' by describing two major ways of thinking about them. He

is not distinguishing two *types* of knowledge here, rather he is searching for what we *mean* when we speak of the same.

The first difference between the two lies, he argues, in what he terms "...conditions *antecedent* to knowledge; differences that is, in the forms of learning or sources of knowledge" (2007, p134). Thus, learning which takes place in the university or other form of institution where students learn from texts, perhaps through listening rather than 'doing', may not unreasonably be considered 'propositional' knowledge or 'theory' (given the arguments presented in chapter 2 of this thesis). Conversely, 'on the job' learning in the workplace, perhaps through carrying out some aspect of work, tends to be categorised as the gaining of 'practical' knowledge. My objections to this way of dividing knowledge are (as I have argued earlier) as follows. For example, is a university based teaching session showing students how to move patients in and out of bed safely or how to bed bath a patient an attempt to give them 'practical' knowledge or 'theoretical' knowledge? Is a similar teaching session in a clinical area showing a student how to bed bath a patient 'theory' or 'practice'? Lum himself also argues that it is illogical to categorise knowledge according to where or how it is taught and/or learned, and that "...few would advocate with any seriousness categorising knowledge according to its antecedent conditions – even though as we have seen, in ordinary talk about theory and practice there is often an implicit assumption to this effect" (p136). Although I would support his argument, his assumption that 'few' would advocate such a categorisation is belied by the NMC (2004) who do exactly that, defining 'theoretical instruction' as taking place in '"...nursing schools and other teaching environments..." (see chapter 2, p50), whereas 'clinical [practical?- DC] instruction', is defined as taking place with the student in "...direct contact with a healthy or sick individual..." (see chapter 2, p50).

Lum's second mode of categorisation is that of:

> ...the tendency to identify knowledge with its consequent conditions. The assumption that knowledge can be described in terms of its outward manifestations – that knowledge effectively *is* those manifestations – has come to permeate almost every area of education over the last two decades. It is the explicit and unquestioned assumption behind every educational procedure that is centred on 'outcomes' or 'competencies', or styled as 'evidence - based'. And it is not difficult to see why an account of knowledge expressed entirely in terms of what it enables someone to say or do should have taken such a hold. In addition to its overt instrumentality, it is completely and utterly at one with the colloquial representation of knowledge and the assumed duality of knowing implicit in the everyday use of terms such as knowing how and knowing that (p136).

Accordingly, if I am able to *write* an essay describing 'how' to move a patient who is unable to stand from their bed to a chair, or perhaps *describe verbally* to another, I could be described as achieving an outcome for the theory of moving such a patient, and indeed, the UKCC has proposed standards required for registration should be constructed in this manner, i.e. "...in terms of outcomes for theory and practice" (UKCC 1999, Recommendation 10, p40). If I *demonstrated* moving the patient, presumably I would fulfil the outcome for practice. If I could do both, I would be deemed to possess both theoretical and practical knowledge. Presumably, the next step would be to 'bridge' or 'span' the 'gap' between these two forms of knowledge before successfully 'integrating' them. Importantly however, despite accepting that it is sometimes essential to be able to distinguish what it is a person might know, 'how' or 'that' perhaps, Lum also argues that it is "...one thing to acknowledge these differences [in outward manifestations - DC], it is quite another to claim there are two forms of knowledge" (p135). As he also points out however, even the attainment of 'outcomes' is not sufficient to show a person possesses knowledge, as it may be that someone may know something without being able to demonstrate that knowledge, they may merely be able to recite facts without understanding or perform tasks mechanically for example. I noted in chapter 2, the issue of a nurse being able to "...describe the series of propositions required to carry out a practical task, for

example, the priming of an intravenous giving set...does not necessarily mean she or he is able to actually out the procedure safely" (2.1, p60).

Lum argues therefore against the increasing use of the attainment of 'outcomes' to assess competency, particularly when, as the UKCC have stated, they should be couched in terms of 'theory' and 'practice', and that the current nursing curriculum should consist of 50% theory and 50% practice. Can the content of each 50% really be categorised as such? Or should we acknowledge that sometimes what we might understand to be theory could give rise to a seemingly practical outcome and so-called practice can sometimes inform so-called theory? For example, using the scenario of moving a patient from bed to chair, it is often the case that a student will ask what would the procedure be if, for example, half way through the manoeuvre the patient suddenly had a cardiac arrest and collapsed on the floor. The only way of suggesting what the student might do next is to draw on so-called 'theoretical' principles which state that the patient should not be physically lifted back onto the bed but attempted resuscitation should take place on the floor, and why. Such a teaching opportunity may just as likely take place in the university clinical laboratory as in a clinical area. Both a 'theoretical' and a 'practical' outcome of competency may be achieved within the one episode.

This then is the nub of the argument. I have already acknowledged and concurred with Lum's dismissal of a tenable linking of 'type' of knowledge and its antecedent conditions. Lum's second point - if the commonly accepted link between knowledge and its consequences - its 'outcomes' has also been demolished, then the link between 'type' of knowledge and 'type' of outcome begins to become untenable. We might now surely start to free ourselves from the constraints of attempting to manufacture and compartmentalise 50% 'theory' and 50% 'practice' when designing curricula for nurse education. To address a question posed earlier in chapter 2, we

may also stop worrying about 'which type' of knowledge needs to be taught first - for example, how to give a particular injection could be taught for the first time and supervised in the clinical area by a staff nurse rather than in the university setting by a nurse lecturer prior to a student's placement in their practice area. That this often occurs at present, only underlines the artificiality of attempting to categorise such knowledge as 'theory' or 'practice'. Whether the steps needed to draw the drug into the syringe are regarded as a series of propositions, or regarded as knowledge in the hands, is not relevant here - the student is being shown and allowed to practice the *action* and is given a rationale for their actions so they may account for them. The anatomy of the limb into which the injection is to be given can be discussed by the student and staff nurse in the clinical area and, if appropriate, in more detail at another time in the university where more time and opportunity is available. They may gain a greater insight into their actions through learning in more depth and at a higher level in the university setting, however, the knowledge they are taught is not of a different 'type' but should be considered to be merely at a different stage of *learning* perhaps on the same continuum of 'knowing'. In a similar manner, when, as a practising Health Visitor I take a student with me to visit a client and her family, I may reiterate what I have already taught the same student in university. I no longer have to consider whether I am somehow upsetting the 'theory/practice balance' by doing so. In other words, what surely is of greater importance now is not the debate about how much of 'each' needs to be learned. It is, as Lum points out, not the epistemological origin of the knowledge required by the student, nor indeed which (theoretical or practical) 'outcome' needs to be ticked in their assessment document, but what it is the student *needs to know* to perform in effectively and appropriately in practice.

In arguing against a distinction between 'theoretical' and 'practical' knowledge then, Lum is not only attempting to bring an end to the pointlessness of "... striving for some

'golden mean' or ideal proportioning of theory and practice..." (2007, p141), he is also claiming:

> ...that *any* account couched in terms of theoretical and practical outcomes will necessarily and quite seriously underdetermine what it is to be competent or professionally capable with the consequence that the extent of what is needed by way of a preparation stands to be radically underestimated (p140).

This argument will be expanded upon later in this chapter.

4.4 The place of moral and spiritual knowledge

The structure of this thesis has been based on an analysis of the three forms of knowledge required in the preparation of nurses. A perennial issue noted earlier is that of a perceived decrease over time in the emphasis given to moral and spiritual knowledge. In order to analyse this aspect of knowledge in relation to present day nurse education, I need at this point to introduce the term 'ethics'. The terminology of 'ethics' is ubiquitous in contemporary curricula designed for health care professions as well as in research governance. Currently, 'ethical' knowledge is arguably considered to be a secular (rather than religious), codified and thus technicised view of moral and spiritual knowledge. One such 'code' for example is that of Tom Beauchamp and James Childress, whose published theory of biomedical ethics reached its 5th edition in 2001 and remains widely taught in Schools of Nursing and Medicine. Their formula is to ensure the practitioner is beneficent, non–maleficent, preserves patient autonomy, and adheres to the principles of justice – the fair distribution of health care resources (Beauchamp and Childress, 2001). Thus, Beauchamp and Childress argue, if the nurse somehow applies these principles to any situation, an 'ethical' outcome will be achieved. There is an interesting contrast between this approach which relies on the external 'application' of a set of principles and the idea of a "...moral, clinical thermometer in herself", described by Nightingale (1888) and at page 23 of this thesis,

which seems to imply an internally generated and sustained source of moral and spiritual knowledge and purpose.

In chapter 2, I discussed what might be meant as moral or spiritual knowledge and described some of the ways in which attempts have been made to inculcate it into nurse education. I have noted that in relation to nursing texts, and in particular the most recently published text analysed in that chapter (Hilton, 2005), a lack of consideration is apparently given to appreciating how a patient *feels*. Nursing 'procedures' are described as just that, and contrast markedly in this respect with Nightingale's writings published well over a century earlier.

However, the foregoing discussion in this chapter now begs the question of the existence of a tenable difference between theoretical and practical knowledge, and if this is not the case, can a separate type of moral and spiritual knowledge be sustainable or should it be conceived of differently? In relation to moral and spiritual, and in light of the above discussion, 'ethical' knowledge, Anne Scott's (2006) argument (see chapter 2.3) that concepts of goodness and badness, moral and spiritual purpose *permeate* the practice of nursing, is an important one. Unfortunately it appears, as noted earlier, this aspect of knowledge is now conceived of as a 'bolt on' codified subject and taught, in my experience, alongside legal issues such as the law relating to confidentiality and informed consent, "law and ethics" being a 'catch all' label. In fact, the Nursing and Midwifery Council (2004) have created 'Standards of Proficiency' in 'Professional and Ethical Practice' which student nurses must meet in order to be admitted to the Nursing Register. These standards require *inter alia* the nurse to "Manage oneself, one's practice and that of others, in accordance with the NMC code of professional conduct, standards for conduct, performance and ethics, recognising one's own abilities and limitations" (2004 p26). The nurse must also "Practise in accordance with an ethical and legal framework which ensures the

primacy of patient and client interest and well being and respects confidentiality" (p26). Finally, the nurse must "Practise in a fair and anti-discriminatory way, acknowledging the differences in beliefs and cultural practices of individuals or groups" (p27). Questions in relation to the NMC requirements, given Scott's argument, must be centred around whether an ability to recite the law governing confidentiality for example, together with Beauchamp and Childress' (2001) ethical framework (do good, do no harm, preserve autonomy and adhere to the principle of fairness), really constitute the possession of a body of knowledge which can be described as 'moral and spiritual'? Does it teach a consideration of how it might feel to be a patient dependent for physical and emotional comfort on another person - the nurse? I would argue that Nightingale's internal 'moral' thermometer might be more successful in achieving this aim.

Martha Levine also argues for the recognition that ethics is more than a 'bolt on' subject in a nursing curriculum, "Ethical behaviour is *not* the display of one's moral rectitude in times of crises. It is the day-to-day expression of one's commitment to other persons and the ways in which human beings relate to one another in their daily interactions" (Levine 1977, p846).

Iris Murdoch (1956) has taken a stand against the proposition that in order to make a decision which is morally 'correct' or justifiable on moral grounds, all that is necessary is to apply an appropriate principle (usually thought of as being derived from a separate type of 'ethical' knowledge, for example Beauchamp and Childress' biomedical ethics (2001)) to the situation in hand. Interestingly, the Standards of Proficiency formulated by the Nursing and Midwifery Council (2004) (previous page), could be interpreted as suggesting that indeed this *is* all that is required. Murdoch however notes that any situation in hand is never an objective reality perceived as such by everyone. Rather, *how* a situation is perceived is the result of the moral

makeup of the perceiver. Scott (2006) argues that Murdoch's position provides an explanation for our abilities to grow both personally and professionally and to therefore develop expertise in recognising the needs of patients, and to offer "...morally good judgements and decisions about (that situation)" (p142). This is *not* the same process as 'learning' a set of ethical principles from a course module on 'nursing ethics'. The stance taken by Levine, Murdoch and Scott in respect of the necessity of making 'morally good judgements and decisions' also resonates well with the concept of practical judgement argued by Carr (1987), Dunne (1991) and Smith (1999) in chapter 2 of this thesis. Their argument is that practical judgement derived from Aristotle's *phronesis* necessarily has an ethical dimension rooted in the good character of the practitioner. Again, is something akin to practical judgement what Nightingale may have had in mind when she wrote of the need for a "moral, clinical thermometer"? I would argue that her insistence on good character in her nurses, sometimes to the detriment of other forms of knowledge, implies this is the case.

One problem with an acceptance of the idea of a *subjective* moral response to situations, particularly in the field of nursing, is the issue of changes occurring in the individual nurse perceiver as a response perhaps to regularly dealing with people (patients) who are very often in pain, or near death and towards whom a nurse may often feel a sense of helplessness. Research by Latimer (2000) identifies the dulling or suppression of emotional responses as a result of *occupational socialisation* being prioritised in the workplace over the development of a *moral and spiritual response* to patient needs. In my experience of students' practice placement reports, students are often praised by their mentors for 'fitting in' and 'working well within the team'. Unfortunately, in order to do this they may have to refrain from expressing concerns about patient care to senior staff. However, occupational socialisation should also be harnessed for the good of the patient too, as discussion later will show.

The history of healing practices described in chapter 1 has illustrated the importance given to the moral and spiritual dimension of practice, whether this be through the housing of the sick in religious institutions or including the observance of ritual and prayer, be that Christian, or from classical times. Although religious support is still offered in clinical settings through hospital chaplains for example, the assumption that nurses also identify their patients with Christ and consider their practice as a service to Him (Risse 1999), cannot now be made. Neither can reliance be placed on what may be known as the 'new religion' of health care or biomedical 'ethics' to fill that void (if indeed it was ever filled by religion). However, Scott's proposal for the engendering of 'virtuous behaviour' probably comes closest to Nightingale's deal of vocation, itself paradoxically founded in Christian traditional virtues. Importantly however, this should be seen, as Scott argues, as part of 'nursing' *not as a distinctive set of principles or body of knowledge* to be applied 'as necessary'. This is surely all the more vital in an environment where technical rationality is increasingly dictating that a patient must have been 'nursed well' if all the boxes on their chart have been ticked, rather than if the patient 'feels' s/he has been well-nursed.

4.5 Towards a more holistic approach to (nursing) education?

The argument articulated so far in this chapter is that there is no tenable distinction between 'theoretical' knowledge and 'practical' knowledge. To this has been added the proposal that 'moral and spiritual knowledge' should be regarded as intrinsic to the practice of nursing rather than as a separate, 'bolt on' subject taught as a set of technical 'ethical rules' in either university or in clinical practice.

In reiterating and further developing this argument, Paul Standish (2007) suggests that an occupation such as nursing which has only relatively recently become grounded in the universities must be under some pressure to "...assert its intellectual credentials..." (p109). Standish however, in arguing that "...to educate a nurse is not

merely to initiate them into a practice but to introduce them to the body of knowledge that informs that practice" (p109) certainly does not appear to be advocating an unequivocal acceptance for the pre-eminence of what he terms, 'theorisation' in the hierarchy of nurse education, and the delineation of knowledge into merely 'that' and 'how'. Standish's argument appears to be rather that a more 'holistic' approach needs to be taken and suggests that in relation to the study of nurse education, and also (I would argue) nursing knowledge itself, the purpose of such education cannot be separated from "... a concern for the promotion of nursing as a profession" (p109). The knowledge which informs practice should therefore be directed to inculcating in students what it is to 'be a nurse'.

He notes, (in relation to the gaining of Dreyfus' *practical wisdom*) that:

> People do not only have to learn a repertoire of skills. They must become initiated into the style of their culture in order to acquire practical wisdom. (What sense do skills have without this?) Like embodied common-sense understanding, cultural style is itself too embodied to be captured in a theory and to be passed on in isolation from a way of life. Barely visible to us under normal circumstances, it is the background against which our actions have their sense. Practical wisdom cannot be divorced from it (p114).

I would like to suggest that this idea of 'style' should not be divorced from a moral imperative to 'do good' in nursing in particular, the style should *be* just that. In fact Standish also argues later in the same chapter, that particularly in vocational education "...there must be professed a commitment to the good of the practice, where profession cannot be simply a matter of signing up to agreed precepts or to a professional code but must involve also the continuing, responsible projection of that good" (2007, p124). His views are reflected (implicitly) in the NMC (2004) Standards of Proficiency document which requires that "...standards of education... enable the acquisition of the particular knowledge and skills, *values and attitudes* pertaining to the (particular) area of practice" [my italics, p25].

In chapter 2 it was also argued by Standish (2007) and Dunne (2007), amongst others, that nurses need to demonstrate the virtue of 'goodness' in their practice, they need to possess the ability to meet the inevitability of experiences for which they have not and never could be adequately prepared within the constraints of "...technicist conceptions of professional competence and practice" (Standish 2007, p123). (A role for practical judgement (Smith 1999) can also be imagined here). Standish claims that this is probably more vital for nurses than doctors as the nurse is the one who stays with the dying patient when the medical team have nothing more to offer (see 2.3, p81 and Standish (2007, p123)). Standish claims that by "...better understanding... the human condition, [one is - DC] better able to care for the sick" (p123).

Almost as far from technical rationality as it is possible to be, Heidegger (1962) claims that the way *Dasein* (the 'being' of human existence) acts and has appropriate thoughts and feelings (in this context, *'is'* a nurse) is not consequent upon knowing 'facts' but in knowing how and why things are as they are. In order for this to be the case, *Dasein* needs to be actively engaged in the 'world', i.e. being-in-the-world. A nurse therefore will always be more than a set of competencies which she/he might achieve and hence 'possess'. The ability, *enframed* in a competency or standard of proficiency, *inter alia,* to run through an intra-venous giving set, or to recite an ethical framework for practice or the common law principles of confidentiality, does not constitute what it is to *be* a nurse. Neither perhaps does an aspect of psychology inform how it might *feel* to be an elderly lady with a fractured arm who needs help to dress herself. What it is to be a nurse is more than the sum of its parts - the ability to carry out a 'practical skill' such as an injection for example, is meaningless in the context of being a nurse unless the action is viewed as part of the wider context of addressing the specific needs of the patient in a physical and emotional sense. Why do they need the injection? What might happen next? In which part of the hospital or home? Indeed, the wider context concerns the whole social and material fabric of the

profession, the institution, and ultimately, the wish to improve the health or to reduce the suffering of another. All these factors (and more) will impact on *how Dasein* acts, as they are actively engaged in-this-world. *Dasein* then, cannot be reduced to a fixed set of skills observed and assessed in isolation from 'the world', as what it is, is the totality of its experiences of being-in-the-world, skills, routines, people, pieces of technology, institutions, Standish's 'cultural style' and so on, from which it cannot be divorced. Heidegger claims "...that it [*Dasein* - DC] stands for a *unitary* phenomenon. This primary datum must be seen as a whole" (1962, p78). Importantly then, if *Dasein* is a complex product of experiences of being-in-the-world, this implies that *Dasein* can *grow with* and also *influence* that world. Is the world of clinical practice therefore of major importance in *growing* that person in the manner we might wish to see nurses *be*? If so, then it is in the world of clinical practice that qualities we wish to see in nurses, rather than those we do not, must be engendered.

In addressing this imperative, Ann Scott (2007) has described the need for nurses to have insight into the morally relevant components of practice, elements such as compassion, respect and honesty – elements remarkably similar in fact to Nightingale's requirements of her students. She adds to these what she describes as intellectual virtues of wit and wisdom and argues that:

> Professional education and professional socialisation should then be a concerted and orchestrated attempt to develop these virtues, among others because the development of these virtues will lead to better nursing practice and to a greater chance of meeting the goals of nursing (p36).

Some of these goals of nursing, as articulated by authors such as Virginia Henderson and the Royal College of Nursing, have been described in chapter 3 of this thesis. In order to reach them Scott advocates:

> ...the exposure of individuals to models of virtuous behaviour through habit formation to education...Our organisational structures, processes and resources must support the nurse in developing the appropriate personal characteristics

> (virtues) and ultimately in the internalisation of the image of the good nurse that regulates the nurse's conception of appropriate practice (p44).

The idea that "virtuous behaviour" can be engendered through "habit formation" can be seen in Aristotle's writings. He discusses how virtues or excellences are acquired in the following, cited by Dunne (1991):

> Excellences we get by first exercising them, as also happens in the *technai* as well. For the things we have to learn before we can do, we learn by doing, e.g. men become builders by building...so too we become just by doing just acts, temperate by doing temperate acts, brave by doing brave acts (E.N. 2.11103a31-1103b2, cited in Dunne 1991, p246).

This process surely requires a degree of socialisation of the 'right' kind in clinical practice but also importantly, in the universities.

I have articulated what I and other authors describe as the constraining, reductionist influence of nurse education's obsession with 'theoretical', 'practical' and 'moral or spiritual knowledge' as competing entities. The role of language in defining and reinforcing these constraints has been illustrated. Indeed, such is the pervasive nature of the terms defining types of knowledge that I have sometimes found it extremely difficult to describe concepts and ideas without resorting to the terms 'theory' and 'practice', or to even think about knowledge without enframing it as such in my own mind. The language used in describing knowledge throughout the literature reviewed here has been 'slippery' and therefore difficult to pin down, resulting in difficulties in discerning what it is we might mean by 'practical knowledge', for example, 'practice' in the broad sense of being able to manage a group of patients or being able to set up a syringe driver? Is it 'knowledge in the hands' or an ability to effectively reassure an anxious patient?

The discussion (above) advocating a more holistic view of nursing illustrates that merely compartmentalising knowledge into 'types' on, for example, a percentage

basis of perhaps 50% theory and 50% practice, hides more than it reveals about *what it is to be* a nurse and therefore what it is a nurse *needs to know*. Even the Report, Fitness for Practice (UKCC 1999), which, as has been noted, advocated a greater proportion of 'practice' in pre-registration nursing courses, displays a degree of conceptual and linguistic confusion when citing an Australian University (Griffith) on whose courses students 'only' spend 960 hours on practice placements, compared to 2,300 hours in the United Kingdom. The Report recommends the use of high quality skills laboratories as apparently used at Griffith, to enable the learning and practising of skills "...in a controlled environment...[they - DC]... can be used as an adjunct to practice placements as well as to replace some. Practice placements can then be used more selectively and effectively... selected from areas of clinical and academic excellence" (1999, p42). This could indeed be a way forward and better facilitate the engendering of Scott's 'virtuous behaviour' through improving the student experience of practice by appointing them to a highly motivated, appropriately educated and empathetic mentor. The more likely scenario at present is that students are allocated to an already overworked and possibly demotivated mentor in a busy practice area where they are regarded as an extra pair of hands (understandably in such areas), to spend the majority of time working with and learning from perhaps an unqualified health care assistant who may rely on 'old fashioned custom and practice' as a rationale for care. Such practices might entail waking all patients at 6am for example in order to be able to change and make their beds by 8am, or the use of uncomfortable methods of moving patients 'quickly'. To 'fit in' the student has to jettison many principles he or she may have already been taught either in university or by qualified staff. Philomena Calpin-Davies (2003) describes the approach of identifying a student's learning needs and allocating them to an appropriate mentor as 'learner-centric', rather than 'placement-centric'. Calpin-Davies notes the current system of allocating students to 'surgical' wards or 'medical' wards:

> ...was a system brought in with the inception of nurse training. On reflection, perhaps it's a system which was always resistant to change and given that [government policy - DC] envisages that delivery of future health care services are determined by the users condition and *not* the clinical setting, it is now a flawed and redundant notion (2003, p59).

These ideas illustrate the degree to which the current obsession with the division of knowledge into 'theory' and 'practice' and achieving an optimal 'mix' has obscured what might be achievable in nurse education if that quest was abandoned. The following section develops this notion of change and makes further recommendations for nurse education policy and practice.

4.6 Some Implications of the study for contemporary policy and practice

Indications of possible consequences stemming from abandoning the distinction between 'theoretical' and 'practical' knowledge and a more holistic approach to moral and spiritual knowledge have been referred to throughout this chapter. In this penultimate section I intend to analyse a recent Nursing and Midwifery Council (NMC) innovation in nurse education policy which at first sight appears to concur with my thesis, that there is no tenable distinction between 'theoretical' knowledge and 'practical' knowledge. I will also use this opportunity to detail and develop an innovation I believe could and should be implemented as a consequence of moving away from this artificial distinction in order to concentrate more fully on engendering that *something else* - that which Richard Smith's (1999) hypothetical Chairperson possessed and exhibited when conducting her meeting (page 81 of this thesis). In addition, I will develop the argument first articulated in chapter 3, that contemporary nurses require a degree level education prior to registration

Nursing and Midwifery Council Circular (2007)

Fortunately, the NMC in its recent (November, 2007) Circular appears to have recognised the deficiencies in the quality or availability of clinical placements, as

articulated by Peach and Calpin-Davies (above). Intriguingly, in spite of its 2004 statement (referred to in chapter 2) in which it defines "theoretical instruction" as taking place in nursing schools and "clinical instruction" as that part of nurse training in which students come into direct contact with their patients and clients, the NMC has recently introduced the term "simulated practice" (NMC 2007). The Circular, when setting out the rationale and the criteria to be met by institutions providing nurse education, refers to Peach's proposals and the encouraging findings of a pilot study carried out by the NMC. This study aimed to ascertain whether the simulation of clinical 'skills' in the university environment could provide an alternative, effective and safe way of learning. The NMC states it will sanction a maximum of 300 hours of the 2,300 hours allocated to the 'practice' component of the pre-registration course as "... clinical training within a simulated practice learning environment in support of providing direct care in the practice environment" (2007, p1). In the absence of any further detail on which clinical skills the NMC has in mind, one can only deduce they include those already taught in clinical skills laboratories in nursing departments within universities. For example, at the pre-registration level I would envisage the teaching of: meeting hygiene needs, manual handling, resuscitation, injections, operating syringe drivers and intravenous pumps as examples. My experience of teaching many of the above clinical skills is that whilst familiarity may be gained with clinical terminology and the operation of various pieces of technical equipment, it is impossible to replicate the necessary interaction with a worried and vulnerable patient, to simulate or indeed engender the necessary *practical judgement* required in any given circumstance. After all, the 'patient' in the university environment will either be a mannequin or a fellow student.

Unfortunately, rather than challenging NHS providers of clinical placements to offer a better quality service, for example adequately educated and motivated mentors with the time to teach students in clinical areas, the NMC appears to have chosen the path

of least resistance and placed more responsibility on universities. What this concession by the NMC does illustrate however, is that although couched in the language of knowledge divisable as 'practice' and by implication 'theory', and in the use of the words "simulated practice" – the NMC Circular *de facto* makes such a division untenable. The NMC's manipulation of the numbers of hours to be spent engaging in 'theory' or 'practice' is even more questionable. What, for example, is the rationale for allowing 300 hours to be spent in 'simulation'; why not 400 hours for example? What exactly is being taught, 'practical' knowledge or 'theoretical' knowledge? Or is it nursing knowledge? The use of the word 'simulation' is, I would argue, merely a device to shore up the edifice that is the pre-registration course, a course constructed using outdated notions of knowledge, and which this thesis has hopefully satisfactorily problematised.

An Alternative Scenario – The Need for Kindness

A much more holistic (in terms of knowledge) solution to poor quality education in clinical practice is, in my view, to challenge NHS employers to provide a learning environment more conducive to learning how to nurse and how to achieve excellence by 'doing'. One method of achieving this is for university based nurse teachers to teach in clinical areas by questioning nurse students about a patient's illness and treatment in the patient's presence, in the manner of a senior doctor who is teaching trainee doctors. The students will be encouraged to ask the patient questions and to examine them. Student doctors learn not only about disease processes and treatment but also about how to communicate with and reassure a patient on the basis of observations of the senior doctor. In a similar manner I would hope student nurses would learn excellence in their future nursing practice through observing, discussing and helping to move or wash a patient, or redressing a surgical wound for example, with an experienced and *motivated* nurse teacher of *good character* who is not part of the ward team shouldering all the extra pressures that this responsibility would entail. I

maintain that there is little value in arguing for more 'practice based' education, as have Peach, the Royal College of Nursing and the media (see chapter 1), in order to address apparent deficiencies in nursing care without acknowledging and making space for the moral and spiritual aspect to nursing, namely Aristotle's *phronesis* – Nightingale's *vocation*. Nurses need to *know how to care,* to be *kind,* and they need to learn this (if not from their upbringing or other life experiences) then from experienced, caring nurses alongside whom they work, whether in a classroom or on a ward. Subsequent learning would take place through the student working ('doing') alongside a clinically based mentor motivated to teach, perhaps as Calpin-Davies (1993) has suggested, in an area identified as meeting the student's learning needs. Teaching in the clinical area, as described above, would also reinforce the status of the student nurse as that of *student* and distance him or her from the role of *helper* (importantly as is normally the case, helper of the *clinical team*, rather than the patient). Despite the reforms of Project 2000 and the Peach Report, student nurses are all too often regarded as an extra pair of hands in a busy and stretched team and, as noted above, have to ignore many of the principles taught in the university. Of course a student can learn a great deal and obtain personal satisfaction from helping, but not at the expense of an initial grounding in excellence from an experienced, appropriate role model. Unfortunately, students are taught by example to work quickly, to get the work finished - the majority of approval given by both unqualified and qualified staff being focussed on this aspect of their learning - and incidentally engineered to satisfy the needs of employers rather than those of patients or profession. In this, it appears there has been little progression from the system of nurse training in force prior to the implementation of Project 2000 (see chapter 1).

The implementation of a system of learning suggested above, promoting an increased emphasis on the development of excellence and less on speed of operation, might

lead to the development and a more useful assessment of a student's character and the degree of kindness shown to patients, than for example, in one "Professional Behaviours Inventory" currently in use (University of Sheffield 2007). This assessment document stretches to six pages and consists of 12 competencies (including "attending to client needs and requests within expected capability" (para.8, p48), "consistency of efforts to achieve the requisite standard of care" (para.3, p46), and "verbal non-verbal interactive skills within the context of care situations" (para.10, p49)). Each competency has 7 statement 'options' and a mentor must choose one that most closely reflects his or her assessment of their student's capability. For example, in relation to the ability to attend to clients' needs and requests, a mentor could choose to assess a student as "not at all conscientious and always delayed in attending to client requests" or at the other end of the scale "is attentive, considerate and conscientious and outstandingly prompt in attending to requests at all times" (para.8, p48). Do these criteria tell us what sort of person the student is? Perhaps, especially when looking at opposing ends of the assessment spectrum we might be able to make a reasonable (but not necessarily, accurate) judgement, but what about the outcomes in the middle range - those most likely perhaps to be favoured by assessors? What can be said of the character of someone who is "conscientious most of the time" or exhibits a "very occasional delay in attending to clients' needs"? (para.8, p48). Do they exhibit *kindness* or a form of efficiency where kindness may or may not play a part? Why might there have been a very occasional delay? Was it because the student was busy attending another client's needs and refused to abandon them? There is no place in this document for an in depth, narrative assessment of the student's character and capabilities, which is essential if (as, I believe) a *phronetic* model of nursing is to be fought for.

The Need for Education

Finally, in addition to the long standing obsession relating to the 'ideal' proportion of 'theoretical' knowledge, 'practical' knowledge and 'moral and spiritual' knowledge a nurse might need to know, an issue I hope I have been able to address, there remains the problem of the 'overeducated nurse'. The dangers inherent in such a notion have been documented throughout this thesis, anxieties having been expressed by nurses themselves, medical doctors, the government and the media for a variety of reasons linked to self interest, whether they are associated with professional power or with a desire to reduce financial pressures on the National Health Service. It is also worth noting that the discussions in relation to the type of knowledge nurses apparently do not need usually refer to what commentators describe as 'academic' or 'theoretical' knowledge and as Ehrenreich and English (1973) have described, the lack of a university education has also been used historically to demean and restrict the activities of female 'healers'.

Perhaps it is not so surprising therefore, that on the one hand nurses are increasingly expected to take on roles previously deemed to be the preserve of medical doctors, including the prescribing of medicines, managing clinics for chronic illness and even undertaking minor surgery (see chapter 3), whilst on the other hand, nurses (a largely female occupation) can achieve registration without the possession of a university degree. Once again, arguments over the necessity or otherwise of a degree level education appear to be influenced by the concomitant requirement of the National Health Service to enlist a large numbers of young, mainly female nursing students, not all of whom may have the academic ability to successfully complete a university degree course. Historically, management of nurse recruitment has impacted on the development of nurse education policy. As Cockayne et al (2007) have argued "One approach involves the manipulation of entry requirements to make first level

registration easier during staff shortages. This approach keeps the minimum level for qualification below a university degree" (p44).

Despite the arguments voiced against 'overeducating' nurses and noted throughout this thesis, research evidence from several countries appears to show that patient mortality rates are influenced by the educational level of hospital nurses. Linda Aitken (2003) notes that prior to her study "... little if anything [was – DC] known about the impact of nurses' education on patient outcomes" (p2). Aitken's study began in the United States in the early 1990s but has now included surveys of nurses and patient outcomes in six countries including the United Kingdom. The study surveyed 50,000 nurses in 700 hospitals and has confirmed *inter alia* that mortality rates fall where the proportion of nurses holding degrees is higher.

How might this situation be reconciled with the need for more nurses and the decreasing pool of young people willing to undertake a difficult career? The strategy of 'widening the entry gate' currently exercised is, I would argue, incompatible with the need to develop an all-graduate profession. In the absence of sufficient NHS funding to adequately pay for a fully qualified and registered workforce, one answer might be to continue the policy development of the health care assistant operating under the aegis of the registered nurse. This is indeed already taking place in the absence of degree level nurses and is in line with other health care professions such as physiotherapists, radiographers, occupational therapists, speech and language therapists and optometrists. These professions all require the completion of a three or four year university degree prior to registration and all have a well established associate assistant role involved in carrying out basic techniques planned and evaluated by the qualified practitioner. There should be few objections therefore to a requirement for nurses to obtain a degree prior to registration other than a misinformed belief about the quantity and level of knowledge required (fuelled, as

chapter 3 of this thesis has illustrated by media representations of nurses) and an unfounded prejudice and belief in the myth that one cannot "be educated and practical at the same time" (Hancock 1992, p2). No-one surely would suggest in relation to any other profession, or even in relation to an individual, that education has a deleterious effect on character? But that has always been the case with nursing. Perhaps (as Liam Clarke (2004) claims earlier in this chapter) there is indeed a degree of misogyny involved here, as in no other professional group employed by the NHS (apart from midwives) is there such a high percentage of female members. Interestingly, and worryingly, midwives are also the only other profession who also do not require a degree before registration. I would argue that far from the educated nurse being a 'dangerous' notion, it is the *under*educated nurse (and midwife) who poses the greater risk to the sick and vulnerable.

4.7 Conclusion

Lum's argument that maintaining the distinction and therefore the continued striving for an ideal 'balance' between knowledge 'types' is ultimately futile, has I believe been well made both in terms of both conditions antecedent and consequent. Knowledge, as viewed either as 'theory', 'practice' or 'moral and spiritual', has been considered as a commodity which can be dispensed in variously sized portions and adjusted to create an ideal mixture - but ideal for whom? I hope I have been able to show that nurse education curricula have been influenced and manipulated through arguments over the proportions of which 'type' of knowledge might best produce a nurse who would 'fit' with the ideal required by any particular interest group, be that government ministers, nurse managers, medical doctors, and even nurses themselves. These arguments go back to the inception of nurse training as we might first recognise it under Florence Nightingale's reforms. I would also argue the legacy of the apprenticeship system is still with us and manifesting itself as part of the opposition to the idea that student nurses should be students first and not primarily a hospital

labour force, perhaps a major component of the outcry against the idea that there was too much 'theory' and not enough 'practice' in the Project 2000 curriculum. The ability of interest groups outside and within nursing to utilise this 'distinction' for their own ends is, I would argue, detrimental to nursing as a profession. Nurses need to be able to determine their own educational requirements in order to gain autonomy in relation to other professions such as medicine, and to obtain control over a body of knowledge *they* have determined *they* require in order that the preparation – performance (rather than theory – practice) 'gap' is bridged. Arguments over the type and level of knowledge nurses need which are founded on ignorance of the contemporary nurse's role may also be detrimental to the interests of patients. A degree level profession is required as Aitken's (2003) research illustrates. Nursing is much more than the product of an optimal, technical mix of knowledge 'types'. The 'internal goods' of practice described by MacIntyre (1981) have relevance here. It is also pertinent to note that the impetus to constrain and categorise knowledge is not restricted to nurse education but is experienced across differing academic curricula. Christine Winter (2007) notes the current school geography Programme of Study for 11-14 year old children, published by the Qualifications and Curriculum Authority in 2007, also uses a division of geographical knowledge into key 'concepts' and 'processes'. Such concepts include *inter alia,* those of 'place', 'scale', 'environmental interaction' and 'cultural understanding and diversity'. She argues, as I have done so above, that there is a real danger that categorising and compartmentalising (here, geographical) knowledge into tidy concepts will:

> ...frame knowledge in ways that exclude, neglect or surreptitiously close off the possibility of other ways of thinking and other objects of knowledge, focusing our minds in a certain direction that stands in the way of the emergence of what ultimately may be more creative, more responsible, more objective ways of knowing (2007, p3).

The closing of minds to the possibility of explanations other than those of a problem with the relative proportions of knowledge categorised as 'theoretical' and 'practical'

within nursing curricula which has somehow 'caused' apparently poor standards of nursing has, I believe, been apparent throughout this thesis. Indeed, I suspect many contemporary complaints about nurses and standards of care are founded not in the wrong balance of so-called 'theory' or 'practice' within nurses' education, but rather within a perceived lack of evidence of empathy, caring, anticipation of patients' needs, moral and spiritual purpose, perhaps *vocation* – again language is insufficient to describe *what* it is that *good* nurses *do* - which binds together the differing experiences they have undergone in their education and afterwards.

Something which does come very close to describing what it is nurses do when achieving what Barbara Carper (2001) might possibly describe as her 'aesthetic pattern of knowing' (see 2.2), is the following quotation from a patient describing the care given by a specialist breast care nurse after her diagnosis of breast cancer:

> The sense of unlimited time and depth of knowledge about a huge range of vital things – surgery, recovery, side effects and how best to manage them, the individual differences, the emotional consequences, the hands-on skills and her availability for anything – to be with you the first time you looked, when you got your prosthesis, for my husband, for my daughter, or me when I want, not according to a schedule...I have seen E many times now and her skills are always impressive but its at times of shock and distress – diagnosis, admission, post-operatively – that they are most evident. It's like the matching pieces of a jigsaw – what she provides fits your needs so well that it makes something of a whole (Niven and Scott, 2003).

The complex nature of the knowledge required to nurse this woman is evident. To imprison it in neat, convenient and seemingly controllable compartments is to demean the knowledge itself, and demean those nurses and patients who rely on it.

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