From 'uncertainty' to 'certainty'?

A discourse analysis of
nursing professionalisation
in South Australia since the 1950s

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Abbreviations used in this thesis

AMA	Australian Medical Association
ANCI	Australian Nursing Council Inc.
ANMC	Australian Nursing and Midwifery Council
ANF	Australian Nursing Federation
ANFSA	Australian Nursing Federation South Australia
ANRAC	Australian Nursing Registering Authority Conference
ATNA	Australasian Trained Nurses' Association
FMC	Flinders Medical Centre
ICN	International Council of Nursing
MHN	Mental Health Nurse
NBSA	Nurses Board of South Australia
NRB	Nurses Registration Board of South Australia
NHMRC	National Health Medical Research Council
NOOSR	National Office of Overseas Skills Recognition
PTS	Preliminary Training School
RAH	Royal Adelaide Hospital
RCNA	Royal College of Nursing Australia
RANF	Royal Australian Nursing Federation
SACAE	South Australian College of Advanced Education
SCAE	Sturt College of Advanced Education
TAFE	Technical and Further Education
WHO	World Health Organisation

Abstract

This study was undertaken using Foucault's genealogical approach to explore an aspect in the governmentality of the nursing profession from the 1950s to the present. It uses developments in the education of nurses in South Australia as a case in point, but includes, at all stages, a concomitant analysis of global trends in the profession and education of nurses. Hence, data were collected from historical documents such as government reports, professional nursing journals, nursing text books and curriculum documents across the period for analysis, from South Australia and Flinders University as a particular case. I thought of these texts as data and examples of the production of discourses about nursing education and practice influenced by the Foucauldian method of process of *The Archaeology of Knowledge* (1972). These discourses produced in both social and professional spheres mirror the sociological knowledge development of the professionalisation agenda that has enveloped the process of professional legitimacy since the Second World War. The interactions are described intertextuality, with each chapter in this thesis presenting the interconnectedness of a variety of discourses. The Foucauldian perspective achieved the purpose of seeking how nursing was shaped by the society and influenced society to form what constituted a nursing professional, to the present time.

'Uncertainty' in the nursing profession was the key concept found in the investigation. Nursing attempted to reduce uncertainty by regulating nursing education, and by setting boundaries for the practice of professional nursing. This governmentality generation process reflects other forms of surveillance developed during the late 20th century, and was used to establish the subjectivity of nurses in terms of 'who' has the right to define nursing and its knowledge systems. The role of the nurse and the requirements for a nurse were emphasised as personal characteristics rather than as professional behaviour when nurse 'training' occurred solely in the hospitals. Who defined the role of nurse and who could be a nurse was decided by medical officers and administrators rather than nurses themselves. As the description of the role of the nurse was expanded to the social sphere, the debates about the appropriate place for nursing students' training was influential in bringing

about change. Establishing nursing education in the tertiary sector facilitated the professionalisation of nursing. I explored curriculum development as an example of the internal governmentality of nursing. The historical analysis of curriculum development processes at an Australian university and its antecedent organisations, showed how nursing educators think about nursing and the role of nurse and how they reflect these requirements in the teaching of nursing students. The way of thinking about nursing and the professional nurse role was also actively observed in the discourses arguing for the use of the thinking tools of nursing such as the nursing process, other problem-solving approaches and latterly for the use of clinical reasoning.

This study uncovered the process of handling uncertainty internal and external to nursing through processes of professional education. Uncertainty control was an essential in nursing education and thinking tools were key in the process for nursing educators to re-set the parameters of nursing. Professional education aims to develop both the individual nurse and the profession, as a whole, which may lead to conflicts of interest. Therefore, it is important for nurse educators to be aware of these potential conflicts of interests in their governmental strategies. It is also necessary to develop an interactive and corroborative curriculum that includes the many stakeholders interested in the development of the nursing profession.

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Declaration by the Candidate

I certify that this thesis does not incorporate without acknowledgement any material previously submitted for a degree or diploma in any university; and that to the best of my knowledge and belief it does not contain any material previously published or written by another person except where due reference is made in the text.

Mayumi Kako

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CHAPTER 1

SETTING THE SCENE

Changes in descriptions of nursing

This thesis seeks to uncover the process of nursing professionalisation by focusing on how 'uncertainty' in nursing has been controlled by external and internal influences since the 1950s. 'Nursing' itself changed over time from a religious foundation to one based on demands from society (Nelson 1996). These changes described in their textual form are observable. For example, a nursing textbook shows that the exhortation for nurses to be 'obedient' in the 1960s changes to calls to be a 'clinical reasoner and providing evidence-based nursing' in 2007. The role change is also seen in the expression of 'the individual role of caring' to 'professional nursing'. What has influenced these changes? This research explores the elements influencing these changes.

It is commonly understood that Florence Nightingale was influential in establishing the foundation of contemporary nursing. What is the meaning of contemporary here? Her principles of nursing are based on scientific reasoning and this has been the springboard to support the foundation of what nursing is now. This scientific foundation of having evidence in nursing is believed to be the contemporary definition of nursing. Nursing at present is defined by international organisations such as World Health Organisation (WHO) and International Council of Nurses (ICN). The definition of nursing for these organisations has changed over time as society has changed. The definition of nursing by WHO (2006, p. 3) is as follows:

> Nursing helps individuals, families and groups to determine and achieve their physical, mental and social potential, and to do so within the changing context of the environment in which they live and work. The nurse requires competence to develop and perform functions that promote and maintain health as well as prevent ill health. Nursing also includes the planning and giving of care during illness and rehabilitation, and encompasses the physical, mental and social aspects of life as they affect health, illness, disability and dying.

> Nursing promotes the active involvement of the individual and his or her family, friends, social group and community, as appropriate, in all aspects of health care, thus encouraging self-reliance and self-determination while promoting a healthy environment.

> Nursing is both an art and a science. It requires the understanding and application of specific knowledge and skills, and it draws on knowledge and techniques derived from the humanities and the physical, social, medical and biological sciences.

WHO's definition of nursing includes the kinds of ability that are required by the nurse indicating what nursing knowledge is. It also situates nursing in society and describes how nursing can be carried out in society. Therefore, WHO's definition contains perspectives from the individual level of nurses to the professional level of nurses. Moreover, according to the international professional organisation for nursing, ICN (2006):

> Nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings. Nursing includes the promotion of health, prevention of illness, and the care of ill, disabled and dying people. Advocacy, promotion of a safe environment, research, participation in shaping health policy and in patient and health systems management, and education are also key nursing roles.

This definition clearly refers to nursing roles such as the promotion of health, the prevention of illness and care for those who are in need. It also indicates that there is a connection between nursing and the social system. On the other hand, compare the above to a definition of nursing in the 1950s as expressed by Henderson and Nite (1955, p. 4):

> Nursing is primarily assisting 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. It is likewise the unique contribution of nursing to help the individual to be independent of such assistance as soon as possible.

They claim that nursing is concerned with assisting a person to achieve their own health goals with the emphasis on 'individual'. The authors explain the purpose of their definition of nursing during this time. Henderson and Nite (1955, p. 1) wrote:

> What is nursing and what is the function of the nurse? These are questions every person who chooses nursing as a vocation should try to answer. While they may be answered in terms of what each person in his experience has seen and heard, definitive answers are not easily found.

It is noticeable to see how the question should be answered. The definition of nursing is explained as being based on nurses' experience and therefore relatively unproblematic.[1] However, its connection to society and the community is not addressed. It can be assumed that the focus of Henderson and Nite's definition is based on what a nurse should do in nursing and the role is not based on societal requirements, other than the nurse being hospital-based and a handmaiden to doctors. The discourses on the role of nurse will be discussed in more depth in Chapter 2.

According to Creelman (1954), the role of the nurse was not clearly stated in the 1950s and was confused with 'the auxiliary nursing personnel' at that time. This thesis will show how nursing's position has been defined by society's requirements by analysing the way nursing has been discussed from the 1950s to the present. Does society define nursing and the role of a nurse? Or has nursing defined the role of nurse? It is clear that there was no one influence on nursing. The process of defining nursing is an interactive process – pushing and being pushed between nursing and society to seek the boundaries and practices of nursing professionals. In other words, professionalisation was externally motivated and a profession is socially influenced. I will describe this unseen boundary in nursing as an 'uncertainty' variable in this thesis. By controlling this uncertainty, nurses are also socialised as a professional group.

'Uncertainty' and professionalisation in nursing

Belcher (2005, p. 284) explained socialisation as "the process of learning the culture of a society (its language and customs), which shows us how to behave and

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[1] I note that this description of nursing was written in the U.S. during the 1950s, In Australia questions over nursing definition took at least another decade to emerge. The more important issue was getting people into and retaining them in the nursing profession (Russell 1990, pp. 43-52).

communicate". Fox (1979, p. 29) also describes professional socialisation as a way of controlling practice uncertainties by undertaking professional training. By overcoming uncertainties in practice the student can become a professional. Fox distinguished two types of uncertainties in medicine (1979, p. 20). One is "from incomplete or imperfect mastery of available knowledge" and another is "upon limitations in current medical knowledge" (Fox 1979, p.20). Fox's claims of uncertainties are based on training in medicine and not in nursing. 'Uncertainties of medicine' is not commonly used language in society, but is emphasised within the discipline. It can be assumed that the recognition of medicine as a discipline in society influences as unnecessary the expression of uncertainties in the societal sphere. Moreover, Fox (1979) asserts that while controlling uncertainties during professional training, it can be assumed that this uncertainty control can be done only when uncertainties are known. However, the strategies for dealing with uncertainty rather than knowing the uncertainties should also be focused on.

In contrast, management of uncertainties regarding the role of nurse were described in the 1950s and 1960s through nurses' characteristics such as obedience, loyalty and needing supervision.[2] For nursing at that time, the boundary of uncertainty was about whether one was a professional or not. In 2007 uncertainties are discussed in terms of professional knowledge, and behaviours such as autonomy, specific knowledge and skills. There has been a shift from personal to professional uncertainties that characterise the uncertainty 'boundaries' over time. It is my intention to seek what these boundaries are in this study.

Belcher's definition does not mention who or what the agents of socialization are: parents, schools and families. Socialisation can be described in at least two spheres of nursing. One is professional socialisation as a group, and the other is personal socialisation into a profession as a professional. However, Fox (1979) only mentions socialisation in terms of the individual experience in medical training, which is also generalizable to nursing.

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[2] See Appendix 3. The characteristics of nurses were described as the elements of assessment.

It is necessary to distinguish 'professionalisation' from 'socialisation' in terms of its impact at the individual level or the professional group level. In this study, when the relationship between the profession and uncertainty in practice is commented on, the focus of socialisation is more likely to be at the individual level. On the other hand, when the relationship between the profession and society is the focus of the discussion, socialisation is more likely to occur at the group level, in other words, nursing professionalisation. Hence, the term socialisation in this study will be used interchangeably for internal and external forces. This perspective will be discussed in more detail in the next section.

Moreover, I also explore what has been happening in nursing professionalisation – the discipline of nursing. My belief is that the elements of being a professional are not only defined by society, but also (the elements of professions) are defined by discipline. This guides recognition of nursing as a profession. For example, uncertainty exists in the daily life of nursing practice at the individual level of nursing. An individual nurse can control his/her uncertainty during nursing practice. This also eliminates uncertainty in nursing professionalisation in terms of the individual nurse's professional development by combining experience and knowledge that is embedded in the practice. Presently, professionals are expected to continue this process to maintain their 'professionality' and the student status is the stage for learning how to control this uncertainty.

In seeking certainty for a nursing professional, what are the influences on nursing practice in terms of uncertainty and how is uncertainty in nursing practice solved over time? Has uncertainty existed from the beginning of nursing or has it appeared during the process of nursing professionalisation? These questions will be investigated in this study. By answering these questions, the development of nursing's future role can be suggested. Uncertainty and certainty in and outside the nursing profession are described in Diagram 1. It shows that uncertainty exists from the individual nurse level to the nursing professional level. To reduce uncertainty in nursing, the tools and strategies for obtaining certainty are described. This thesis seeks to understand how uncertainty becomes certainty through the operation of key texts and by a discourse analysis of such texts.
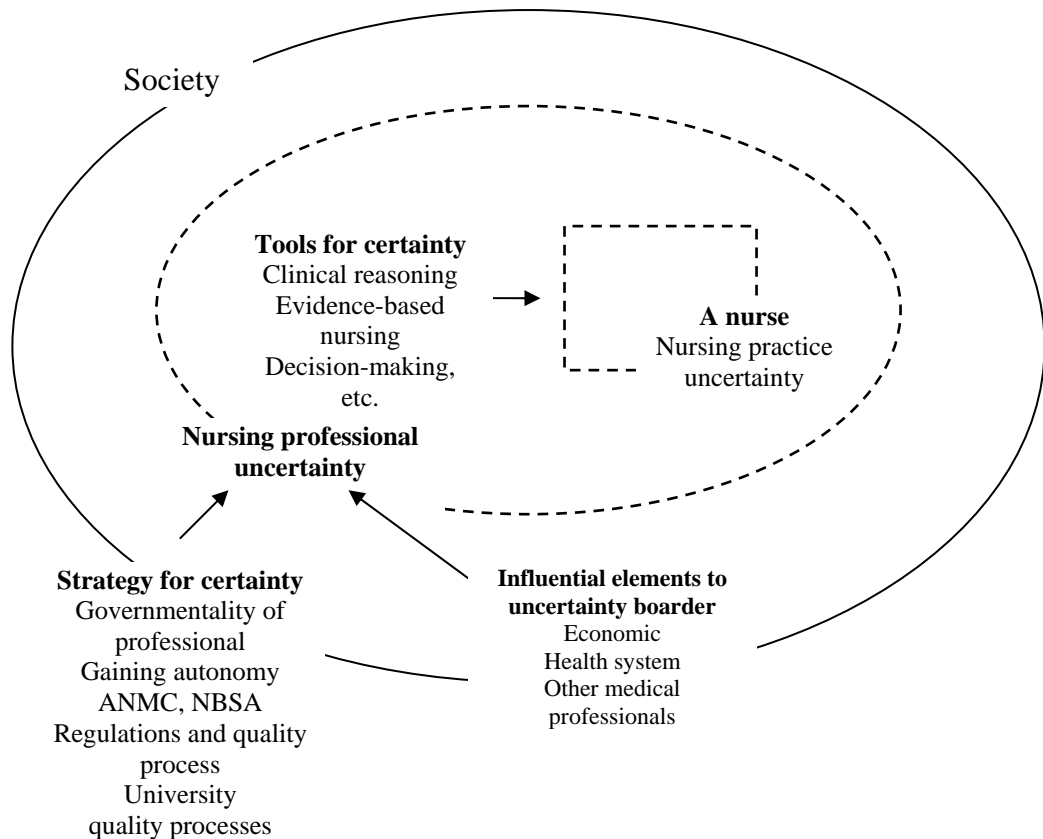
Diagram 1: Uncertainties and the nursing profession

What can turn 'uncertainty' into 'certainty'?

Nelson (2000) wrote in her book, *A genealogy of care of the sick,* that "the history of professional nursing is a history of scientific and moral imperatives". She claims that nursing professional development has been influenced by ethical developments in nursing, which is also influenced by society and nursing care delivery itself. This explanation implies that the social contract changes from nursing as valued in its religious and moral meaning to a nursing professional meaning. Her description of nursing professional development can also be explained from a perspective of nursing based on religious values being transformed by wider societal values, influenced as well as by science and technological development. As I showed in the contrast of nursing descriptions between the 1950s and 2006 (see pp. 1-3), nursing is explained in a societal context rather than personal context in more recent years. What governs nurses' practice changed from one of vocation and supervision by

doctors in the 1950s to autonomy and self-regulation with clinical reasoning skills in 2007. Hence, the principles governing the nursing profession have shifted.

However, these changes remain shadowy, in that the religious values of nursing and socialisation of nursing continue to exist at the same time and may well do so in the future. Moreover, not only is the nursing profession influenced by external forces such as socio-economical movements, but nursing and nurses has empowers itself by developing nursing knowledge along other disciplines and gaining autonomy as professionals. I believe that professionalisation is on ongoing process involving both external power and power inside the profession. This tension from inside and outside is likened to an inflated balloon.

Nursing as a gas-filled balloon

The external/internal tensions of nursing can be described by using the analogy of a balloon. Like inflating a balloon with helium, when the balance between the inside of the balloon and its outside is maintained, the balloon will stay in the air. Over-inflating the balloon damages it and too little inflation does not allow the balloon to stay in the air. The balloon is a metaphor of the nursing profession. The purpose of this study is to describe the sequences that keep the balloon round and afloat. The sequences that form the nicely balanced balloon are based on various discussions. For example, a variety of gases may be considered, and the environment external to the balloon such as air temperature. The material from which the balloon is made will also be discussed. Who, then, will decide what is good for the balloon (nursing profession)? It can be known what is needed to keep the balloon intact, but, what or who is responsible for this? Moreover, as nursing professionalisation was described as a process of dealing with uncertainties, who or what constitutes these uncertainties? Power refers to knowing the suitability of gas and balloon's material and knowing the external environment of the balloon. In other words, nurses can decide what is needed in terms of the balloon's material (i.e. education) and environment (i.e. social expectations of the nurse role) based on levels of certainty in nursing.

The power of certainty

Foucault (1975) argues that power makes the uncertain certain, in other words, unknown matter becomes known matter as a result of a 'power shift'. He uses the example of anatomical descriptions in medicine over time. Foucault showed that anatomical descriptions have changed over time and raises questions about what factors influenced these changes from the 18th century to the present. Medical doctors were not able to explain, recognise or understand some of the phenomenon they observed in the traditional medical context. Foucault looked for factors that changed the relationship between what they saw and what they did not see.

Foucault states that traditional medicine at the beginning of the 19th century was increasingly taken over by clinical medicine (1972, p. xii). What traditional medicine aimed to achieve was to eradicate sickness and bring 'health' back to the person. The person was treated holistically. However, the introduction of clinical medicine and its practices of diagnosis and treatment made the human body an object of investigation and analysis. Furthermore, in the process, clinical medicine segregates the normal from the abnormal condition of the body. In other words, in traditional medicine a description of symptoms was given, whereas in clinical medicine such symptoms became a disease diagnosis.

The purpose of medicine also changed from focusing on 'health' recovery to ensuring the patients were returned to a 'normal' condition. Thus, in clinical medicine, doctors who are able to recognise what is wrong in the body, with their specialised knowledge, gained power in labelling what is normal and abnormal as the diagnosis of disease. Moreover, clinical doctors gained power by applying their knowledge and skills to treatments such as surgical procedures and pharmacological therapies. Foucault used the example of 'madness' to demonstrate the segregation of normal and abnormal (1967). People with madness are separated from society and confined in a hospital as the group having the abnormality. The term madness is defined and assessed by an authority figure who can confine these people. The judgement of madness distinguished between people who are normal and abnormal.

Thus, clinical medicine became powerful because it enabled the labelling of normality and abnormality. In other words, labelling abnormality is about moving

from uncertainty to certainty within a medical discipline. This labelling also brought into being the concept of 'object' in medicine. When clinical medicine points out the normality of the body, the body has become the object of the medical doctors' investigation of abnormality and patients lose their personality and individuality. This change from subjectivity to objectivity comes from the difference in depth of knowledge. When traditional medicine was used at the beginning of 19th century, doctors used their knowledge based on empirical information, gained from experience. The symptoms of the patients' body are regarded as the key to information about assessing the body. These symptoms rely on the patients' claims and subjectivities. However, the development of technology enabled people to see the micro level of the body and created greater different knowledge of medicine. The information that cannot be known from the patients' symptoms (subjectivities) can be revealed by objective information through medical technology. Knowledge of medicine became established as evidence-based knowledge. Hence, science and its role in knowledge development led to a power shift in clinical medicine.

It also needs to be asked if nursing too developed a labelling capacity in terms of nursing practice. From the 1950s to the early 1980s uncertainty in nursing was discussed regarding whether nursing was a profession or not and resolving internal uncertainty is still an evolving process employing thinking tools such as the nursing process, problem-solving and clinical reasoning. This study also examines curriculum development since the 1950s to investigate how nursing was understood and taught.

The purpose of this study

I will apply Foucault's thoughts and perspective on medical knowledge and practice to nursing professionalisation in this thesis. His perspectives on the formation of knowledge will support an understanding of how nursing knowledge as a discipline developed. Just as *The Birth of the Clinic* provided a new perspective on medicine and the patient, the shift from subjectivity to objectivity in medicine also affected nursing. It is also my intention to examine nursing and the components that constitute the nursing profession. Therefore, I will analyse discussions of 'uncertainty' in nursing and how such discussions have changed and what made

them change. These are the central concerns of this study. The purpose of this study therefore is to use Foucault's genealogical discourse analysis to answer the following:

- How has managing uncertainty in nursing practice changed since the 1950s?
- What has influenced the development of nursing as a profession since the 1950s?
- How have approaches to education influenced and been influenced by nursing's professional agenda?
- Thinking tools used by nurses have changed over the past 60 years: what has influenced these changes and what has been their impact?

To answer these questions, this thesis will:

- retrieve, interpret and weave together these changes in the texts since the 1950s to the present time, revealing the tensions that form the contemporary nursing profession and examine the various shifts in from 'uncertainty' to 'certainty' in nursing;
- situate the present state of the nursing profession internally (especially nursing education through curriculum development) and externally (for example, regulation of the nursing profession);
- assess what the future holds for the nursing profession in South Australia.

Texts as data and its role

The data were collected through texts such as nursing textbooks, nursing journals and archives written from the 1950s until 2007. The nursing textbooks were limited to those that outlined concepts, principles and definitions of professional nursing. Nursing journals such as *Nursing Research* (started 1952), *International Nursing Review* (started in 1954), and *Journal of Nursing Education* (started 1964) were selected as representative of the early period and to this study. Australian nursing journals chosen were; *Australian Nursing Journal* (started 1903) and *The Lamp* (started in 1943). The 1950s was chosen as the starting point because it was a decade of many societal changes, especially in technological developments. The social

changes beginning in that decade influenced nursing in its development as an independent discipline and autonomous profession and helped form the nursing profession as it is now (Maggs 1987). The texts will be analysed for their form of writing and the purpose for which they were intended. It is not only the purpose of this study to examine how these writings have changed over time, but also how they are differentiated in terms of subject matter.

The formation of discourse

Fairclough (1992, p. 64) explains well the intentions that constitute writings on nursing in his discussion on the formation of a discourse. He states, "Discourse contributes to the constitution of all those dimensions of social structure which directly or indirectly shape and constrain it". He sees discourse formation not only from the use of language itself, but also from the system that forms its context. For example, the term 'sister' was used for nurses until the 1980s in Australia. However, this term implies the exclusion of male nurses and the term 'nurse' was introduced as the number of male nurses increased and as part of a desire to attract more males to nursing. The term 'nurse' in Japanese was also known as *'kango-fu'* until 2002. The term *'kango-fu'* was changed to *'kango-shi'*. The background for this change is that the term *'fu'* or *'kango-fu'* means 'women' in Japanese and nurses are now not only female as the number of male nurses is increasing. As a result, the term *kango-fu* is not suitable for the name of a nurse and so the new term nurse, *'kango-shi'* has been introduced. *'Shi'* from *'kango-shi'* refers to a person who has duties and it does not imply gender. Like these examples, the language use is not the only focus but also the background of the language use; its meaning is investigated in this thesis. In changing and newly introduced nursing terms, there have been discussions regarding the matter. Statements themselves and discussions about forming and altering concepts are described as a discourse. I consider discourse in this study as the agency that provides me with the key to understanding the formation of internal and external influences on the nursing profession. In the next section, 'discourse' will be explored in detail.

Can we define discourse and its analysis?

Discourse and discourse analysis change in terms of their context when these are discussed. The smallest unit of discourse was called *énoncés* by Foucault (translated as 'statement'). This small unit of discourse can be expressed as an act of speech in daily life to discussions of matters that relate to the social environment, such as term for the nurses' name. Due to its complexity, Fairclough (1992) commented on this point that discourse is "a difficult concept, because there are so many conflicting and overlapping definitions formulated from various theoretical and disciplinary standpoints". MacDonnell (1986) also claims:

> Discourses differ with the kinds of institutions and social practices in which they take shape, and with the positions of those who speak and those whom they address. The field of discourse is not homogeneous.

Therefore, it is meaningless to define what 'discourse' means outside of the context in which it was produced. What actually constitutes and what is constituted by a discourse defines their clarity. In other words, the body of the discourses will control the context of the discourses. Hence, discourse analysis is influenced by the institutions that produce the discourses. I will focus below on the interconnectedness of internal and external *énoncés* of nursing professionals, namely intertextuality.

Intertextuality of discourse

This study particularly sees the formation and transition of discourses historically rather than focusing on what the constitution of the discourse does through conversations, interactions or other forms of written or spoken dialogue. Foucault focused closely on discourses and how these change, hence showing how any concept was produced historically (see *The Archaeology of Knowledge* 1972). Using such a framework examines how these themes are interconnected and also brings what appears as unchanging concept formation to an historical light. He suggests that concepts are formed through:

> …the rules of formation [of concept] operate not only in the mind or consciousness of individuals, but in discourse itself; they operate therefore, according to a sort of uniform anonymity, on all individuals who undertake to speak in this discursive field (p. 63).

He further explains that concept formation occurs within the discourses without interference from other elements (Foucault 1972, p. 63):

> In any case, the rules governing the formation of concepts, however generalized the concepts may be, are not the result, laid down in history and deposited in the depth of collective customs, of operations carried out by individuals; they do not constitute the bare schema of a whole obscure work, in the course of which concepts would be made to emerge through illusions, prejudices, errors, and traditions. The preconceptual field allows the emergence of the discursive regularities and constraints that have made possible the heterogeneous multiplicity of concepts, and, beyond these the profusion of the themes, beliefs, and representations with which one usually deals when one is writing the history of ideas.

He explained that the formation of a 'preconceptual field' begins concept formation. This field combines other concepts and creates a knowledge domain that is described within any analysis of a history of ideas. The presence of discourses in the preconceptual field are analysed and the manoeuvres that occur between the discourses are a central part of this study. This process is described as intertextuality.

Fairclough (1992, p.4) emphasises the importance of seeing the combination of different discourses under particular social conditions that produce a new, complex discourse, historically. However, the discourses do not completely change; rather things fade from prominence but remain (as almost a sub-text) as a part of our understanding. This failure to completely obliterate a point of view, and its historical effects lends any set of discourses formed through this intertextuality a sense of lack of coherence, cohesion and 'bumpiness'.

Discourse analysis in this study

This research explores what concepts underpin the discourses and what the production processes are behind them. In other words, the discourses surrounding the formation of concepts concerning contemporary nursing are investigated. Therefore, discourses are defined as discussions about nursing in the chosen texts

and how these relate to co-occurring societal developments or the social context. For instance, these discourses represent an essential component of presenting nurses as professionals. Such a presence in the texts indicates how these discourses appeared commonly in the texts and constituted what counted as the process of professionalisation.

The context of discourses is defined by what constitutes the discourses; for example in the critical approaches it concerns power, knowledge and ideologies that exist around the formation of discourses (Philips & Hardy 2002, p. 20). This operation of these ideologies drives an investigator to see the differences through undertaking a discourse analysis. There are various investigators who categorise the discourse analysis according to this context. For example, Traynor (2006, p. 64) provides a historical view of papers using discourse analysis to clarify the differences in those papers. He explains that complexities and differences in approaches to discourse analysis is due to the situation that forms of analysis "developed in different ways in different disciplines" (2006, p. 63) and as such in order to make this clear he provides an overview of the multiple dimensions of discourse analysis. Traynor (2006) claims there are two axes to describe the dimensions in discourse analysis. One axis focuses on the variety of theoretical positions taken to explain the interactions between individuals and language. The other axis comprises the "…continuum of foci of discourse analytic studies, from a concern with the techniques and competencies involved in successful and unsuccessful conversation…to an interest in language as a mechanism of ideology…" (p. 63). Within the overview of two axes Traynor categorised four strands of discourse analytic approaches. These are: 'Identifying code': language properties and linguistics; 'Use and interaction': conversation analysis and ethnomethodology; 'Interpretive repertoires': studies of occupation; and 'Social discursive practices': studies of discourses and power (2006, pp. 63-4). The approaches are different because each is informed by a different theory of what is meant by discourse and so this causes differences in the theoretical approaches which the investigator takes. Moreover these strands are not mutually exclusive but can be used in various combinations to explore and elucidate how discourses constitute the things, subjectivities and ideas they present to the reader or writer.

Philips and Hardy (2002) also suggest that what counts as a discourse analysis varies according to the theoretical perspective taken by the researcher For example, Philips and Hardy (2002) propose six areas for discourse analytic studies: social control, as exemplified in studies employing critical discourse analysis, which focuses on what produces and reproduces power in organisations; studies of work, focuses on narrative produced about the nature of work; business practice, investigates how business practice is formed as a result of broader discourses from the power distribution and interests from industries and societies; discourses of difference which sees the differences in gender, age, and ethnicity; identity production that explores how individuals identify with and are constituted within organizations and environmental studies that focus on the discourses producing new concepts such as toxic waste (p. 29-33).

In these suggested areas, the fifth area 'identity production' particularly focuses on "the production of individual and collective identities within organizational settings" (p. 32). In other words, such studies identify processes, either individual or collective, that constitute identities that are produced within occupations. This study falls into the topic 'occupational identity' because it focuses on the processes of within the discipline and profession of nursing that have constituted nursing identity and for nurses to be recognised as professionals. Such research identifies the discursive processes this occupational group has used in order to be recognised as professional since the 1950s.

Philips and Harvey (2002) show a different level of classification from Traynor (2006) in discourses analysis. Their categorisation is based on which subject is studied in discourse analysis rather than within which theoretical framework a study is embedded. This point brings back Traynor's previous comments about the differences that occur due to disciplinary context. In this study, the focus is on the continuum of processes surrounding nursing professionalisation and also the continuum of constructive processes that constitute nurses' thinking about nursing, therefore this study can be categorised as located in both axes of Traynor's (2006) discourse analysis classification. The first axis indicates that the interaction between individuals and language. Although this study does not employ the methods such as interviewing through direct interaction with individuals, the text, as data, shows

individual's opinions and comments are taken as examples that come to constitute the discourse of professionalization in nursing. Using texts in this way mirrors the relationship between the individuals and language shown in interview or conversational data. This study is also located in Traynor's second axis, where a discourse analysis sets out to explore how language is used to set ideologies (Traynor 2006, p. 63). This form of analysis shows the operations of language in the formation of ideology. Such an emphasis is Foucauldian and investigates pre-ideological formations and the contests over what counts as a professional nursing identity.

Foucault looked at the a priori of the formation of ideology; how it is formed and not the ideology itself, in the belief that ideologies change and are set discursively rather than coming entire with the structural formation. Powers (2001, p. 53) describes this form of discourse analysis as, "not specify[ing] the action to be taken by expressing a preference for one outcome over another, or one speaking position over another, as a feminist analysis would". Foucault is also interested in the relationship between power and knowledge (Campbell & Arnold 2004). They explain, "Foucauldian DA [discourse analysis] considers how discourses position people and how this [positioning] reproduces the relations of knowledge and power". Gergen (1999) explains Foucault's perspective of power as being more focused on the insinuation of power into the ordinary and sees how we demonstrate our subjugation to power in how we continue in our taken-for-granted everyday practices. He also writes, "Foucault was centrally concerned with subjugation by various groups who claim "to know", or to be in control of the production and use of truth claims – especially about who we are as human selves" (Gergen 1999). Hence, Foucauldian discourse analysis deals not only with the situation where the discourse occurred, but also the background and the processes that produced the discourse. On the other hand, this is also the weakness of this approach. Powers (2001, p. 64) points out the limitation of such a discourse analysis depending on the methodology that the investigator takes. "since no claim is made for the absolute truth of the claims made in a discourse analysis, one of the limitations is that other, competing claims are possible regarding the same discourse". For this reason, care needs to be taken about the claims of any such analysis, and it is therefore important to present evidence, detail the operations of the texts and discourses and show how the concept was formed in the ferment of debate. Hence, this study does not seek the absolute truth about nursing

professionalisation for all time, but rather limits its analysis to one illustrative case showing the international, national and local discursive effects on one curriculum and educational processes in the education of nurses in one location. Its claims are therefore more circumspect but nevertheless will show that one location is affected by many distant influences that enrol the participants in ways that may be common to other locations.

An explanation of how I view the relationship between society and the individual in terms of a nurse and nursing as professionals is essential. Diagram 2 on next page shows how the discourses are situated in this study. Discourses are produced in various social levels. In the professional sphere as a professional group, discourses are produced as texts such as professional journals, textbooks and reports etc. In the social sphere, discourses are produced by taking the form of governmental and organisational reports etc. Discourses produced in the different spheres shows their positioning of discussions. In this study, I will focus on how discourses produced in the different spheres are retrieved and seek out how the nursing profession is formed through these discourses.

The concept formation of 'certainty' in nursing can be described by applying this process that Foucault describes. The 'uncertainties' in nursing incorporate various elements that influence the formation of 'certainty' in nursing. These elements are: the power of scientific development, nursing knowledge development and the power of nursing profession, and so on. Each chapter will present and interweave the elements that operate to present a form of the concept of certainty as discourses in nursing.
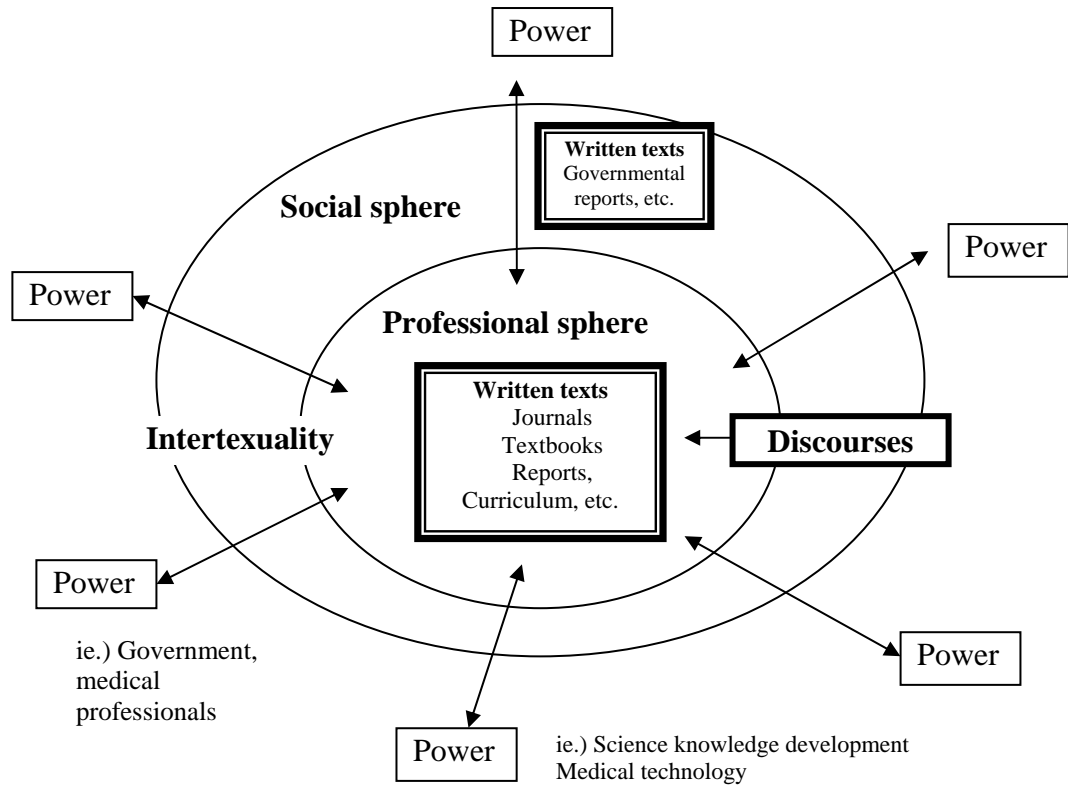
Diagram 2: The explanation of discourse in this study

The concept of 'episteme' and history in Foucault's thinking

In *The Archaeology of Knowledge* (1972), Foucault describes the way of seeing history through tool (concept) development. Analysis of tools (concept) allows insight into fundamental ways of thinking which have generated incidents and situations. Foucault (1972, p.3) explains:

> These tools have enabled workers in the historical field to distinguish various sedimentary strata; linear successions, which for so long had been the object of research, have given way to discoveries in depth.

Foucault names tools such as "the models of economic growth", "quantitative analysis of market movements" and "accounts of demographic expansion and contraction", etc. Foucault (1972, p. 3) continues, "The old questions of [the] traditional analysis…are now being replaced by questions of another type: which strata should be isolated from others?" Thus, Foucault changes the thinking about history not only by asking about the links between events, but also by asking which forces have been the most important. The elements making history are composed of

particular discourses over time. Foucault describes the changes in discourses and explains a new way to see history (1972, p. 5):

> …the great problem presented by such historical analysis is not how continuities are established, how a single pattern is formed and preserved, how for so many different, successive minds there is a single horizon, what mode of action and what substructure is implied by the interplay of transmissions, resumptions, disappearances, and repetitions, how the origin may extend its sway well beyond itself to that conclusion that is never given – the problem is no longer one of lasting foundations, but one of transformations that serve as new foundations, the rebuilding of foundations.

Foucault's main concern is how a discourse has been formed and what factors are at work on the formation of a discourse. He is not only assessing the matter discussed, but also analyses the factors that produce the discussions. This process is called genealogy and it seeks to "show how the present is the product of a variety of contingent-accidental events of power struggles that could have ended differently from the way they did" (Kusch 1991, p. 167). Moreover, he believes that the speech act is dominated by unique rules such that the context of knowledge cannot be interpreted during another or later period; i.e. each historical period's experience and knowledge cannot be easily understood in another context (Sakurai 1996) because many of the traces or debates that constituted the formation of the concept are now rendered as background or so completely taken-for-granted that their influence at the formation of the concept is misunderstood in the present .

Foucault analyses the situation that produces the discourses as the rule of discourse or '*episteme*'. *Episteme* is defined as the group of thoughts or perspectives that give regularity and boundaries in a particular period's thought.[3] Foucault (1972) describes episteme in this way:

> …it [episteme] opens up an inexhaustible field and can never be closed; its aim is not to reconstitute the system of postulates that governs all the branches of knowledge (*connaissances*) of a given period, but to cover an indefinite field of relations.

His explanation of *episteme* also illustrates why a discourse's intertextuality is often

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[3] The term of *episteme* has its origins in the Greek episteme (knowledge).

not obvious in each *episteme* and its correlate orders of discourses. Furthermore Foucault's view of history is not to write about what happened in the past, but what (especially in terms of power relationships) made the history, as written, told in a particular way. Foucault sees genealogical analysis as the way to retrieve the power relationship between history and *epistemes*. In this sense, the traditional historical view is different in terms of the incidents that are explained in chronological order. Traditional ways of historical study are based on chronological events. Foucault, instead, concentrates on denying that this is what occurs and that (1972, p. 12):

> the indispensable corrective of the founding function of the subject: the guarantee that everything that has eluded him may be restored to him; the certainty that time will dispense nothing without restoring it in a reconstituted unity; the promise that one day the subject - in the form of historical consciousness – will once again be able to appropriate, to bring back under his way, all those things are kept at a distance by difference, and find in them what might be called his abode. Making historical analysis the discourse of the continuous and making human consciousness the original subject of all historical development and all action are the two sides of the same system of thought. In this system, time is conceived in terms of totalisation and revolutions are never more than moments of consciousness.

The shift from the historical description of events through thematic retrieval creates a portrayal of knowledge and truth claims about what happened as a seemingly smooth in transition. It denies how history is made through human action and practices – presenting it only as an activity of events explored chronologically. For Foucault such eventalism failed to explore how a point of view came to dominate, how a group of people became thought of as acting in certain ways, and how concepts came to be understood as meaning one thing rather than others. A Foucauldian analysis is also believed to seek lost subjectivity in history and return it to its rightful ownership. Nelson (2003, p. 214) describes this process as 'history as method'. What is to be sought is not the 'correctness' of historical events, but what lay beneath the events and Foucauldian discourse analysis is how these effects can be brought to the surface for exploration, discussion and critique.

The attitude towards history and discourses in this study

Observing the texts, identifying discourses within them since the 1950s was undertaken in both the social and the professional sphere indicating the researcher's attitude towards understanding the texts' data as history. The traditional historical study is based on what happened and what causes events. Berkhofer (1995, p. 28) explains this approach to history as normal history based on Kuhn's idea of 'normal' science (Kuhn 1996, pp. 1-5). Berkhofer (1995) adds, "Normal historical practice depends on the use of professionally accepted methods for obtaining facts about the past from surviving evidence, or sources" (p. 28). In this sense, the main concern is the truthfulness of evidence explaining historical events. Therefore, history is described and based on the truth of incidents, but begs the question of whose truth or perspective is being presented or believed about those events.

However, historical events are not the main concern of this study. Rather than prove the trustworthiness of events, it is more interested in how what is counted now as the present came to be, and how in such a present coming to be particular discourses came to dominate in the shaping of nursing's professional development/ education. This study explores the literature and the historical incidents as they have been written and expressed in texts. Wall (2006, p. 227) describes this historical approach as a form of 'text analysis'. She explains that text analysis "as a methodology, is a means of gathering and analysing data and making likely interpretations of that information". It is concerned, not with "what actually happened, but rather analyzes how the *arrival of knowledge* came about". Moreover, this study tries to establish the sequences of professional development in nursing as this reflected developments in influential knowledges from wider society. The details in the data of what actually happened are less important than how the changes presented themselves in texts. The main concern therefore is with changes in thinking about nursing, and how what counted as professional was transformed over the period of this study. It describes what led up to the "arrivals" of such ideas about nursing and what counted as a professional in relation to concurrent social changes. By focusing on the formations of these discourses, it will be possible to trace the progress of knowledge and professional development in nursing. Again, Foucault's approach to historical analysis is considered appropriate for this research. The connection between

Foucault's perspective and my study perspective will be described in more depth in the next section.

The study perspective and Foucault's metaphor of history

Foucault symbolises the process of the history of ideas as standing at a point downstream in a river and looking back upstream, where the ideas originate. He (Foucault 1972, p 135) writes:

> We can now reverse the procedure; we can go downstream, and, once we have covered the domain of discursive formations and statements, once we have outlined their general theory, we can proceed to possible domains of application. We can examine what use is served by this analysis that I have rather solemnly called 'archaeology'.

I interpret his thoughts for my study as follows. The process of retrieving archives (as texts) is like seeing the branches and fruit on a tree (because what they express is invisible) and recovering the discourses and themes from the archives is like uprooting the tree and observing each root by finding out what each root means for the branches of the tree and fruit. When I think about Foucault's thought as applied to nursing, I believe nursing is now recognised as a profession because nursing education is now part of higher education in Australia. Nurses are able to be specialised and continuing education for nurses is widely available.[4]

In present-day nursing education, nursing educators believe that the core cognitive processes – the thinking tools for nursing such as 'clinical reasoning', 'nursing process' and 'evidence based nursing', etc. – bring certainty to nursing professionals. What lies behind the development of these tools and their influence on nursing knowledge development? Behind these developments lies a set of formative discourses. Foucault labels the set of discourses *'enonce'*, which is the product of these discourses. Their form changes within the timeframe from the 1950s to the present day. The unit of *enonce* will produce *episteme*, which consists of the group of thoughts in the particular period – from the 1950s to 2007 in this study. The focus of

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[4] All nursing education to become a Registered Nurse was conducted in higher education institutions from 1984 in New South Wales. The transition to higher education for undergraduate nursing was completed by 1993 in the rest of Australia. New South Wales, South Australia, Victoria and West Australia had at least one higher education undergraduate programme from the 1970s.

this study is not about the truth of an incident, but about interpreting the idea of history in nursing. I believe that this process will enable us to realise what we need to develop the nursing tree so that its future is healthy.

The structure of this thesis

This thesis will investigate discourses of 'uncertainty and certainty' in the external and internal contexts of the nursing profession. [5] I will start by exploring the discourses external to nursing. The relationship between the nursing profession and society will be discussed in Chapter 2. I will analyse and position the discourses of professionalisation in terms of describing how thinking about the nursing profession has changed in sociology and particular sociological conceptualisations of 'profession'. Sociological knowledge is considered as providing the basis of nursing professionalisation in **Chapter 2**. This process will lead to Chapter 3 and a discussion of historical discourses about the nursing profession. **Chapter 3** presents and discusses the production of those discourses. The textual data will be closely analysed in terms of the use of words, their context of and how they were constituted. Medical technological developments transformed the role of the nurse, with nurses taking over some responsibilities and authority from doctors by mastering medical skills. The skills gained from technological developments are augmented by thinking tools that helped nurses develop systematise thinking frames. **Chapter 4** will examine thinking tools such as nursing process, problem-solving and clinical reasoning. These thinking tools play a key role in promoting the link between nursing practice and theory. The symbolic metaphor of tool for certainty in nursing – nursing process discourse – has also influenced nursing education. How these thinking tools influenced the nursing curriculum is central to this chapter. Examining this also sheds light on the nurse educators' attitude toward the nursing discipline. **Chapter 5** will describe the curriculum as a 'container' for nursing thinking tools with some detail on the situation in South Australia which is described in more detail in chapter 6 and 7. I analyse the historical text as data by reflecting on the thinking tools for nursing such as 'nursing process' and 'problem-solving' in **Chapter 6**. The nursing curricula in one school in South Australia, are analysed as a concrete illustration of the themes covered in this thesis. In **Chapter 7** I will investigate how

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[5] Diagram 3 in next page indicates the overview of this study.

nursing thinking tools are accommodated while the concept of curriculum changed and what was the implication for this. This chapter will focus the period from the 1980s to 2007 so that it will bring the current position of nursing professional education. C**hapter 8** presents the conclusions and implications for the future direction of nursing professionals and nursing education.
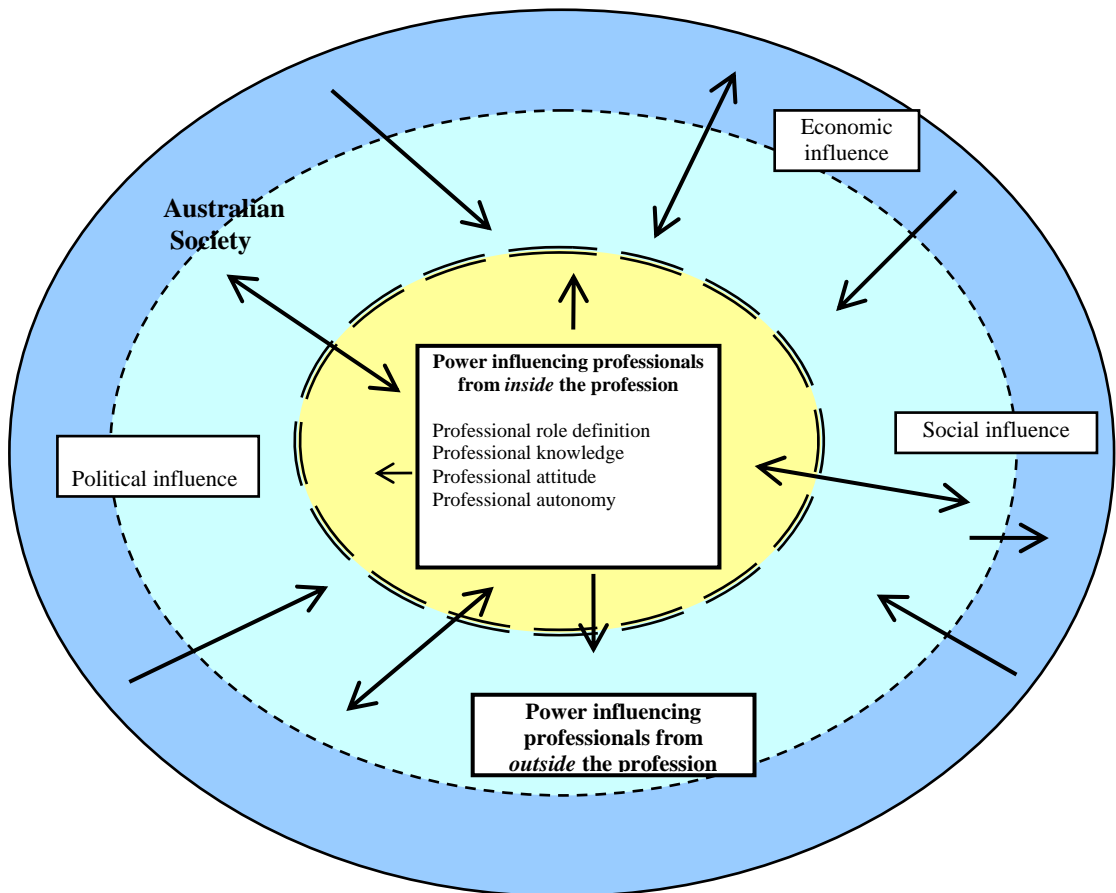
Diagram 3: The overview of this study

CHAPTER 2

DISCOURSES OF PROFESSIONALISATION

Introduction

In Chapter 1, I used the analogy of an inflated balloon to describe the processes of nursing professionalisation. Exploring how the external factors maintain the balloon's inflation is the purpose of this chapter. Before describing nursing professionalisation, questions remain such as: what is the nursing profession? and how is the nursing profession defined? What maintains the balance between influences outside and inside nursing and what factors are most influential on nursing professionalisation? In this chapter, the answers to these questions are to be explored from a sociological framework. I consider how social changes in Australia are an important factor influencing the formation of professionalisation discourses. Therefore, these outside influences, political, social and economic will be described briefly first. It is the contention of this thesis that many issues are linked in the social/historical period during and since the 1950s in Australia when many of the nursing theories were developed.[6] Nurses reflected these discourses into nursing as part of forming its current professional status while they thought through professional discourses by Carr-Saunders and Wilson (1964), Parsons (1964), Etzioni (1964) and others.[7] Thus the nursing professionalisation agenda is interrelated with these discourses. Nurses used such influence to establish the legitimacy of their position. In this chapter, after the brief description of social changes I will discuss how the discourses are described in the current competency standards (ANMC 2006a) in use in Australia. This will provide the basis to explore how professional characteristics originated from the perspective of the relationship between nursing professionals and society.

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[6] Nursing theories mentioned in this thesis are largely developed in U.S. When the term of nursing theory (theories) is mentioned in thesis, it implies nursing theories developed in U.S.
[7] The detail will be discussed in later pages.

Social changes in Australia

As with many societies, Australian society has experienced a remarkable number of changes since the 1950s. This section will show how the discourses of professionalisation are used to portray nursing and its educational practices by contextualising nursing in the society in which it is embedded. The following section describes social changes since the 1950s, a period which experienced enormous technological and economic development and influenced the emergence of nursing professionalisation discourses.

Modernising Australia since the 1950s

The Second World War created a turning point in economic development in Australia. Industrial employment between 1939 and 1944 increased by 50% or more. The post-war period in Australia is also described as that of significant industrial development similar to many other countries in this era (Kagatsume 1988, p. 200). Behind this industrial development was a massive population increase made essential due to the loss of the workforce as a result of the war. After the war, displaced European immigrants joined the workforce in industries such as the building industry, processing industry and clothing/textiles industry as these did not require highly skilled people. Birrell (1987, p. 15) described the population increase after the war as follows:

> Population growth was also a major stimulant to the construction and property development industries. Immigrants came to play a crucial role in the manufacturing and construction industries. Recruitment of unskilled or semi-skilled labourers was particularly heavy from the wave of southern European immigrants (mainly Italians and Greeks) who came to Australia in the 1950s and early 1960s.

Kagatsume (1988, p.215) explains that the population growth was 6.34 million between 1947 and 1976, and consisted of 40% of immigrants. After the Second World War, the countries of origin of immigrants also changed. Traditionally, the majority of immigrants were from the United Kingdom but now there were increased numbers from European countries such as Greece, Italy in the 1950s and countries such as Yugoslavia, Turkey, Lebanon and during the 1970s, refugees from Vietnam joined the mix. Bolton (1990) states that the gross domestic product rose about five

percent every year between 1952 and 1965. As the immigrants' countries of origin changed, the priorities accorded to international links between Australia and other countries changed.

Russell (1990, p. 44) wrote that "Australia started to move away from these traditional links with Britain and towards closer links with the United States". This change also influenced the relationship between the countries in Asia and those in the Pacific. Australia's international relationships also influenced nursing greatly. As previously mentioned, the post-war development was based on immigration and international relationships with other counties. Nursing in Australia was influenced by this trend in terms of a shortage of its workforce occasioned by the rapid population expansion after the war caused a shortage of nurses, this in turn forcing the introduction of a foreign workforce to resolve the shortage (Durdin 1991, p. 158).

Lees and Senyard (1987) wrote in their book called *The 1950s: how Australia became a modern society, and everyone got a house and car*, that the standard of living improved dramatically in this era. Housework was done with electric appliances such as vacuum cleaners, washing machines, refrigerators, and so on. Transport and communications also improved with motor cars and television. Television started in 1956 and the Olympic Games were hosted in Melbourne. Lees and Senyard (1987) wrote, 'Most importantly, the fifties saw Australia's adoption of the United States as its model'. They continue to explain how Australia tried to modernise:

> It was the process of making Australia a modern society which brought it into the U.S. orbit. After the War, the United States, not Britain, emerged as the standard for countries which wanted to modernise. Production and transport were largely mechanised in the Unites States, but not in Australia. In the fifties, it was mainly through U.S. companies that Australian industry tooled up to provide the machines, vehicles and petroleum products which were to transform the country (p.1).

The United States emerged as the most powerful country in the post-war world. Before the 1950s, Australians regarded themselves as "a frontier white settlement which produced raw materials, and was protected by British Authority" (Lees and Senyard 1987, p. 5). Production relied heavily on selling raw materials. However,

new technologies were introduced into Australia, such as a car industry and electronics industry. Thus, Australia started modernising and developed an international influence. Bolton (1990, p. 90) described this as follows:

> Australia's good fortune during the 1950s and the 1960s was founded on a continually expanding world trade and a stable international monetary system, both largely the result of measures initiated by the United States to safeguard western capitalism.

In an atmosphere of capitalist inspired expansion, the Australian post-war governments set out to develop the nation with an emphasis on economic development. Technology was regarded as an important way to improve the country. In the area of technological development, medical technology cast an enormous influence on nursing.

Even with a larger population due to immigration from European countries, the unemployment rate dropped. In the 1964 financial year, the unemployment rate was 1.5% and stayed low until in the early 1970s. However, inflation and demand for imports led to an inflationary cycle. These pressures on the economy and government policy reactions then brought an economic slow down (Kagatsume 1988, p. 221). The unemployment rate kept rising after the mid-1970s and the rate reached 5-6% after 1978 (Kagatsume 1988, pp. 221-2). Thus, in Australia, the post-war economic boom had finished by the early 1970s. Since 1974, the manufacturing industry especially has declined and employment in manufacturing has dropped to 20% in the national workforce. Falling employment during the 1970s generated macro-scale discussions among political parties, economists, and unions, and many local communities were adversely affected by this economic deterioration (Kagatsume 1988, p. 222).

In this atmosphere, social movements such as the anti-war movement,[8] students' rights movement, and women's movement grew. Kinder (1982, p. 367) explained the background of these movements as follows:

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[8] Australia's participation in the Vietnam War and the increase in the number of causalities and deaths from that war created a significant antiwar movement. In 1972, all Australian forces were withdrawn (1988, p. 172).

> During the 1960s Australia moved from the influence of
> its British colonial heritage to become more dependent
> on the rapidly expanding power of the United States. In
> this period, partly as a result of increased material
> prosperity, new groups had arisen who were ready to
> challenge the existing order; blacks, students and women
> questioned every aspect of western civilisation and
> critically evaluated the existing alternative theories of
> how to achieve a better society.

Under these societal pressures, people started to question the social structure and the
difficulties existing in it, which had not been discussed before. For example, in
Adelaide, the women's liberation was active since 1969 and it reached its peak in the
end of 1974 (Kinder 1982, p. 376). She described this movement in Adelaide:

> The majority of women's liberation activists were
> students, housewives or professional workers, with a
> limited understanding of factory worker trade unionism.
> Initial activities taken by working women themselves,
> such as nurses' strikes and ensuring debate in 1970…

The early movement was keen to move into action after the processing of in-depth
consciousness-raising. After establishing a series of projects, the movement in
Adelaide promoted a self-generating momentum for change (Kinder 1982, p. 376).
The five years of the Adelaide movement provided not only services and generated
ideas but also provided an ideological base for changing the women's status in
society.

It was not only women who questioned the existing social and political order. The
students' rights movement was also started in this period. According to Bolton (1990,
p. 170) described this:

> Protest was meanwhile side-tracked into the self-
> indulgent issues of student politics. Encouraged by the
> examples of campus radicals in the United States and
> France, movements sprang up during 1967 and 1968 at
> several Australian universities, where the Vietnam
> question was joined to a variety demands. Some sought
> an alliance of students and workers to bring about the
> immediate downfall of capitalism; others simply wanted
> a stronger student voice on university committees. Each
> group varied in its aims and tactics, for despite

> conservative alarm there was little effective nation-wide
> direction to student protest.

In spite of this, protest did lead to Australia's withdrawal from Vietnam and student became more involved in the design and evaluation of their education. People had become increasing dissatisfied with institutions and political authorities. The social norms that had been taken for granted for decades were challenged. One of these norms was the notion of authority in society. In the new order, there was the belief that authority can be challenged.

In summary, these social changes since the 1950s in Australia were a background influencing nursing to establish their professionality in society. Nurses took on these influences such as workforce shortages, medical technological development and changes to women's status at a time when the professions were also changing. In the next section, I will explore how the characteristics of professions are discussed over time. I start from a description of the current state of profession as presented in the Australian nursing competency statements and the relationship of these elements will be discussed through understandings about what represents a profession from its definition and discussion within the sociology of professions.

Characteristics of professions

The characteristics what counted as professional changed over time. It has varied from the characteristics of so-called classic professions, religious leaders, medical doctors and lawyers to more contemporary professions. In this section, I will explore the characteristic of professions in terms of the position between society. As I show in Diagram 4 below, profession can have many meanings in terms of how a profession is situated. Whether a profession is discussed in as a part of social structure or as an agent, social theorists have different explanations of the characteristics of a profession.

As Edgar (1993) noted about social theorisation, theories exist at the same time and continuously influence each other, while also producing contradictions in the way a social event or activity is talked about. As I mentioned in Chapter 1, this layering and difference in positioning of texts produces intertextuality and hence the inconsistency

in texts. Therefore, the theories that emerge in this chapter from an examination of sociological discussions, are to be understood in the broader content of societal influence on the nursing profession.
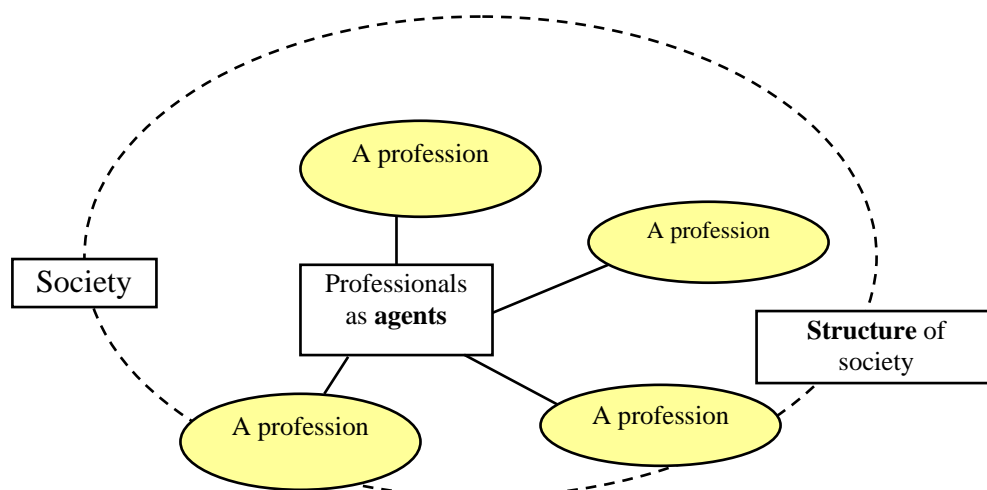
Diagram 4: The focus of professional theories

Current state of nursing profession

The current status of the nursing profession in Australia is described in the Australian Nursing and Midwifery Council (ANMC) competency standards. This Council expects a registered nurse to practice "independently and interdependently assuming accountability and responsibility for their own actions and delegation of care to enrolled nurses and health care workers" (ANMC 2006a, p. 2). Moreover, the standard explicitly describes nursing competency as having four elements: professional practice; critical thinking and analysis; provision and coordination of care; collaborative and therapeutic practice (ANMC 2006a, p. 3). [9] This nursing regulatory authority defines nurses' professional role and the social expectations toward it as a profession. Such a statement gives the impression that nurses are now professionals whose practice is articulated explicitly. Nurses are independent and autonomous therapeutic professionals who think and analyse critically, provide and co-ordinate care in collaboration. Gordon and Nelson (2006, p. 7-9; 13-4) argued that the 'virtue script' has been superseded by a knowledge script over last 150 years.

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[9] See Appendix 9.

They explained that nursing skills and knowledge was not valued enough although evidences of the relationship between the hospital const and nursing care are visible. Instead seeing a nurse intelligent and skilled person, "…they tend to reinforce nursing's "old image" as good work performed by kind and nice people (women)…" (Gordon & Nelson 2006, p. 14). Indeed, nurses were expected to be a 'good nurse', whose moral character is emphasised. Moreover, being a good nurse helped to legitimatise nursing, because in the value of 'good' it contains the important element to be a profession. The current form of virtue script is seen such as in the form of the code of ethics.[10] Adding to being a good nurse, 'knowledge' was essential to be a professional according to social professional theories. The construction of body of knowledge in nursing is also part of nursing legitimatisation project.[11] During seeking and producing nursing knowledge, nursing was also defined by utilising the thinking tools such as nursing process, problem-solving and clinical reasoning and so forth.[12] Nurses are now believed to be knowledgeable to utilise these tools and carries moral as well.

Thus, the current belief of nursing profession includes important key words such as practise independently and interdependently, accountability and responsibility according to the competency standards. I use these key words to analyse nursing professionalisation since the 1950s in terms of the sociological discourses about what counts as a profession. The competency components also refer to the standards for nursing practice providing the possibility of accountability for the nursing profession.

Nurses know what nursing professionals are

In the 2006 competency standards, the registered nurse is expected to practice independently and interdependently. This expression implies that a nurse is responsible for their work using nursing knowledge and experience to act on their clinical decisions, for which they are responsible and accountable. 'Practice interdependently' shows that the nurse is not a lone agent in the health care system. The nurse works with other health professionals in a collaborative way. This

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[10] See more explanation in Chapter 3.

[11] See more discussion in 'Body of knowledge' in this Chapter, pp. 49-50.

[12] See more discussion in Chapter 4.

keyword is also used in the domains of the competencies. In the 'collaborative and therapeutic practice' section, it clearly describes that the nurse "Communicates nursing assessment and decisions to the interdisciplinary health care team and other relevant service providers" (ANMC 2006a, p. 9). In this description, nurses' actions are seen as vital to be communicated with the health care team. The authority to assess and make decisions by a nurse is then shared with others in the health care system. In the following section, I will explore how the professionalisation discourses were mobilised in terms of the concepts of authority and power in nursing to show how its agenda were advanced.

The defining characteristics

In the 1930s, a nurse was not considered to be an independent agent in the health care system. At the time, what was considered to be a profession were the classic professions such as lawyers, medical doctors and religious clerics. Carr-Saunders and Wilson (1964) surveyed the degree of professionality in the 1930s and concluded that "The ancient professions of law and medicine stand near the centre" (1964, p. 284) and what makes these professions the central is:

> The practitioners, by virtue of prolonged and specialized intellectual training, have acquired a technique which enables them to render a specialized service to the community. This service they perform for a fixed remuneration whether by way of fee or salary. They develop a sense of responsibility for the techniques which they manifest in their concern for the competence and honour of the practitioners as a whole…

Their definition of professions involves 'technique', obtained through training and used to serve the community responsibly. These classic professions have clear requirements as to what makes the profession legitimate. The central professions such as medical doctors and lawyers, fulfil the requirements of professional education, professional associations that support the professionals, discipline, conduct and the relationship between the public and professions. Members of these professions were also required to swear an oath in some form, legitimating

professionalism with a code of ethics.[13]

Carr-Saunders and Wilson (1964, p. 285) clarified the position of nursing by comparing it to dentistry:

> Dentists, for instance, do not merely learn how to put in fillings and make false teeth; they study general biology and in particular the structure, physiology, and pathology of teeth. Nurses and midwives, on the other hand, are concerned only with the applications of science. This distinction, none too sharp even when the technique is scientific, is less clear when the technique is institutional.

They recognised that dentistry is not only based on techniques such as filling teeth but is based on specialised knowledge. They excluded nursing from the professions due to the lack of and vague of constitution of nursing knowledge. In this sense the relationship between central profession and nursing is distant. It is not only the constitution of knowledge of an occupation, but also its 'responsibility' which shortens its distance from the central profession (Carr-Saunders 1964, p. 285). They used the term 'responsibility', to mean that professions have an obligation to accomplish tasks based on personal judgement (1964, p.286).

Parsons critiqued and extended this view of the classic professions. Parsons' structural functionalist analysis or systems theory analysis maintains that society drives people's behaviour and his perspective focuses on "how various parts of society function to maintain social order" (Germov 2005, p. 32). The definition of classic professions and Parsons' view of the professions shows some differences. The view of the classic professions is that lawyers and medical doctors are motivated by 'self-sacrifice', which is a taken-for-granted. This taken-for-granted view enables us to imagine professions as a 'sacred profession' and its practitioners as in possession of a 'vocation' to practice (Takeuchi 1971, p. 55). Parsons contends that a profession is not only defined by these motivations such as self-sacrifice and the welfare of others. Parsons rather sees a profession as defined by people's motivations in the context of what society demands:

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[13] The characteristics of profession by Carr-Saunders and Wilson (1964) have similarities with that of Etzioni's (1964). See the discussion by Etzioni, p. 39.

> In much of traditional thought about human action the most basic of all differences in types of human motivation has been held to be that between "egoistic" and "altruistic" motives. Correlative with this there has been the tendency to identify this classification with the concrete motives of different spheres of activity: the business man has been thought of as egoistically pursuing his own self-interest regardless of the interests of others, while the professional man was altruistically serving the interests of others regardless of his own. Seen in this context the professions appear not only as empirically somewhat different from business, but the two fields would seem to exemplify the most radical cleavage conceivable in the field of human behaviour (1964, p. 36).

Parsons defined professionals as "those occupations that possessed and applied highly generalized knowledge" (1964, p. 36). As Parson states this, when professions are based on knowledge, professions develop their professionality by exploring their knowledge interests. The crucial difference between a business man and a profession is where their interests are situated as well as what motivates them. Although Parsons did not use the term 'responsibility' in his discourse, the activities based on a professional attitude; 'serving the interests of others' would produce responsibility, because the motivation with vocation and altruism are virtue in his discourse.

'Calling' as integral to profession

Nurses, have only recently, since the late 1980s, claimed power and authority as part of what counted as being a professional, modified by considerable debate in educational and sociological circles. Early work on nurses' professional status was legitimated by using the term, "calling". This form of legitimated nursing was apparent in the Carr-Saunders and Wilson's texts on the relationship between calling and tasks in nursing (1964, p.117):

> The ancient vocation of nursing has passed through vicissitudes without parallel in any other vocation which comes under review here. This may be traced to the fact that until recently the only nursing worthy of the name was inspired by religious or at least philanthropic motives. Nurses were 'called' to a life devoted to the alleviation of suffering, and when the 'call' was not given or not heard, the task was left undone or was abandoned to persons to whom the honourable title of nurse was not appropriate.

Before nursing came to use sociological knowledge to legitimate its call to be considered as a profession around the mid-20th century[14], the women who were in the religious groups promoted the religious women to be of a certain moral character. In actuality, nurses and midwives had existed in many societies before medical doctors and lawyers emerged. Nurses' work was strongly believed to come from their 'calling' and dedication to meet the needs of society. In the mid-19th Century, 'the religious' with their vocation based on a sense of calling and high moral character were highly respected and were often leaders in nursing (Dingwall, Rafferty & Charles 1988, p. 29; Nelson 2001, pp. 68- 72). "The religious women who helped to lead the professional associations with the higher degree" (Nelson 2001, p. 5) were not seen as professionals, like the central professions of law and medicine. Because nurses were portrayed as religious and moral women, nurses did not and were not expected to have either authority or power in the secular/ professional sense.[15] Moral work equated with good nursing and was not associated with the sense of controlling nursing and or being influential in society. However nurses started talking about professional behaviour which was closely linked to moral behaviour. For example, nurses used an oath to strengthen this perception. The Nightingale Pledge was composed by utilising an adaptation of the Hippocratic Oath (V.A.B. 1910, p. 271). The Nightingale Pledge was originally adapted by Lystra Gretter in 1893 and "published by the alumnae association of that school [Farrand Training School for Nurses] and copyrighted in 1936" (Wilson 1948, p. 255). The 1910 by V.A.B. article did not associate the sense of 'professional' in nursing. However the 1923 article associated the Pledge with professional behaviour (Anonymous 1923, pp. 192-3). The anonymous author describes the usefulness of the Pledge:

> Both these uses of the Nightingale Pledge should result in a
> higher code of ethics among the members of the Alumnae as
> well as among the new graduates. What we require of others we
> are more likely to heed ourselves. If an alumnae association is

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[14] However, 'calling' is still used for legitimatisation of professional. For example, The Weekend Australian on 3-4 November, 2007 reported Rosemary Bryant who is the executive director of RCNA, describe in choosing nursing as a career comes from calling, "The type of people who go into nursing are not there for the money. They want to be paid properly, but they are not there for money" (Anonymous 2007).

[15] These religious women were not only women who worked as nurses in this period. There were also women working who were not associated with religion. Moreover, expert nurses clearly did have authority and power answering from their expertise but this was not the power and authority of the classic professions.

> really anxious that its members shall live and work on a high
> professional plane, it is most fitting that it should use the
> Nightingale Pledge as a reminder of the obligations a nurse
> assumes when she [sic] joins its ranks.

The Nursing Pledge was used as a legitimisation method for the nursing profession where ethical behaviours was equated with professional behaviour, like the definition of profession by Carr-Saunders and Wilson (1964), the Pledge is relate to the code of ethics, which works for moral imperatives of nursing professional as well. The context of the Pledge shows that a nurse was considered competent by being good assistant to doctors, committing to health and welfare promotion of the community to a level of the 'good citizen' (see Appendix 13). 'Power' to maintain nurses' professionality does not work outward (to society), but is directed inward (to individual nurses). The authority and power implicit in nursing practices were not discussed as authority until mid-20th century. Nurses were professionals only in terms of the ethical dimension of professions. Characteristics such as obedience, being uncomplaining and so on, were legitimised in the education and practice of nurses and the Nightingale pledge formed nurses' attitudes maintaining nursing's non-professions status (Nelson 2000, p. 162).

Can experience raise professionality?

'Sense of calling' has been utilised in nursing professionalisation discourses for legitimisation of nursing profession. This professionality is based on the social assumptions about professions. Gross (1958) added different discourses to Carr-Saunders and Wilson's (1964) view of professions. Gross (1958) believed that difference in amount and quality of experience also divides the non-professional and the professional (see Diagram 6), and claims that the difference between professions and non-professions exists on a continuum (1958, p. 81):

> At the professional pole of the continuum we postulate
> ideally the complete presence of six of these criteria[16]
> [that have been explained previously] in their full
> development… At the other end of the pole, the job, we
> postulate the complete absence of these criteria. That is:

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[16] According to Gross (1958), the six criteria are: the unstandardized product; degree of personality involvement; wide knowledge of a specialized technique in the profession; sense of obligation to one's art; sense of identity with one's colleagues; essential to welfare society

> the work is completely standardized; the relation to the client or customer is entirely segmented; the worker has no previous knowledge; the traditional technique is employed and friendship, money, etc., are of first importance; there is no group consciousness; and the work is not essential to society…Actual professions and jobs may be placed on the continuum and the behaviour of persons in those occupations may be interpreted with respect to how close they are to either pole.

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│                   ┌──────────────────────────┐               │
│                   │     Quantity increase     │               │
│                   │   (i.e. experience period)│               │
│                   │ Possible increase of       │               │
│                   │ experience, responsibility,│               │
│                   │ personal judgement,        │               │
│                   │ knowledge                  │               │
│                   └──────────────────────────┘               │
│                              │                                │
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│   Non-profession                          Profession          │
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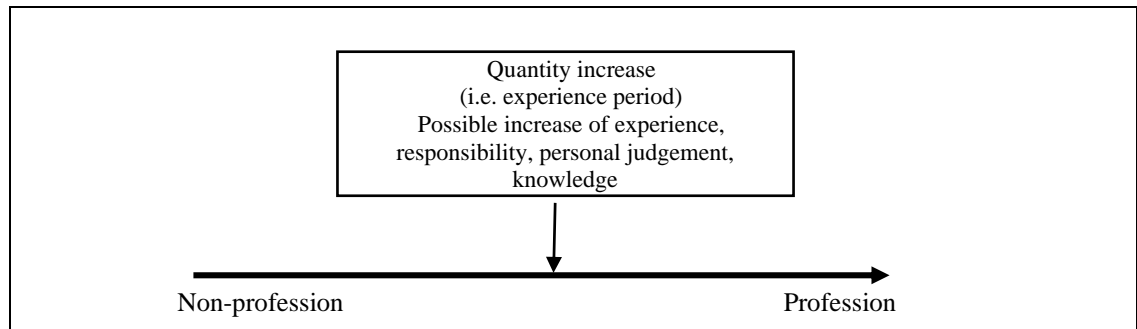
Diagram 5:   Definition of a professional by Gross (1958) and Carr-Saunders and Wilson (1964)

Gross (1958) argued that it is knowledge and experience that shift the degree of professionality in each of the occupations he examined. Gross examined well how experience impacts on professionality, however he failed to mention authority which is produced within the relationship between professions and society. On the other hand, although Carr-Saunders and Wilson (1964) did not use the term authority, they use 'responsibility' as an attribute of central professionals. Responsibility is expanded by gaining experience and leads to personal judgement. Nursing was distanced from the central professionals when they made this claim and 'experience' with a moral dimension was regarded as a more important element to raise professionality.

Gross's belief explains the Carr-Saunders' and Wilson claim that the low professionality of nurses can be reduced by 'higher training'. This was described as training in co-operation with doctors and as "training character" (Rafferty 1996, pp. 26-34). Carr-Saunders and Wilson (1964, p.121) analysed the low professionality of nurses as follows:

> Until lately, however, the nurse worked under the direction of doctor, and there was little element of co-operation. While the nurse must continue to work under direction, the tendency is toward co-operation which is made possible by the higher training. The vocation of nursing is becoming professionalized. Would Miss Nightingale, if she revisited the scene, find her fears realized? [17, 18] We think not, and to the extent that this is so, we must look for the explanation, not in the fact that all for which she contended is unnecessary, but in the fact that a skilled and dignified profession may also be in her sense of 'calling'.

This text demonstrates the ambivalent position of the nursing profession in terms of nurses' responsibility over their practice. Carr-Saunders and Wilson claim that nurses could not decide their practice other than following doctors' directions. When the nurse was viewed as 'co-operative', nurses were expected to know the doctors' work well so as to support their work. The amount of training and experience (as shown in the word 'skilled') mattered only in so far as this enabled a nurse to be more 'co-operative'. Therefore, in the term 'training', there is no sense that nursing is based on knowledge other than that embedded in the practice of its skills. What enabled a nurse to co-operate was task-oriented nursing, which supports the doctors' role. In the end, their assessment that nursing is 'becoming professionalised' is linked not only to co-operation with doctors 'made possible by higher training' but also to the 'sense of calling'.

Constructing relationships between society and nursing

The social belief that nurses' work is based on a calling, dominated until the 1970s, neither was the relationship between society and nursing discussed other than as service: consequently the relationship was not mentioned in social theories. Within the social theorists' discourses, the sense of 'calling' existed as another form of belief and thinking. When someone is motivated to be a nurse, their vocation provides the obligation to work for society. Calling is a theme in some discourses on

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[17] In the previous page 119 of *The profession*, Carr-Saunders and Wilson described that Florence Nightingale opposed the proposal of the state registration in U.K. in the 1880s. Her opposition was "incompatible with her ideals of nursing" (1964, p. 119). The opposition to the state registration was also proposed by Miss Luckes, a Matron at London Hospital (Rafferty 1996, p. 51-52).

[18] Nightingale established the nursing school which was established at St Thomas's Hospital in London, 1860. Godden (Phillips 2007) analysed this situation, "…she [Nightingale] became very bitter…the nurses technically enrolled in a school and were taught for a year. But as she soon found out, the hospitals were using them as cheap labour".

professions. McCoppin and Gardner, who are nurse educators, describe society's view of professions in the 1950s as follows (1994, p. 37):

> The accepted view of professions in the 1950s emerged from functionalist sociology: professions were a special category of occupation in which experts carried out work of a socially important kind for individual clients. Professions were therefore a valuable and necessary asset in any society. The authority of professionals was legitimately based on their possession of a unique body of knowledge, and clients could trust them because professions had an ideal of service, an ethical code, state licensure, and recognised associations.

What they are describing is the dominant discourse of what counted as a profession during the 1950s and they relate this to the dominance of one mode of social analysis over any other in the sociology of professions. From this dominant perspective, nurses were viewed as outside of or not of professional status, especially in terms of the lack of a unique body of knowledge.

While McCoppin and Gardner (1994) highlight the use of structural functionalism to legitimise professional status, a further form of discussion that influenced strategies for claiming professional status was the use of Weber's theories on class, status and party for understanding the role of nurses in society. Weber's view of society is that it is organised by bureaucratic rationality (1968, p. 956). He explains that rationality in the modern Western society is created by people "for the optimum means to a given end is shaped by rules, regulations, and larger social structures" (Ritzer 1993, p. 19). Professionalisation discourses were influenced by Weberianism and the definition of profession was actively discussed in nursing literature coming to be enshrined in many nursing textbooks from the U.S. For example, Etzioni, an acknowledged Weberian (1961), was cited by Potter & Perry (1985) – a common nursing text book used to educate nurses and he defines five professional characteristics that have their basis in theory and emphasise role expectations:

1. A profession requires an extended education of its members in addition to a basic liberal foundation.
2. A profession has a theoretical body of knowledge leading to defined skills, abilities, and norms.

3.   A profession provides a specific service.

4.   Members of a profession have autonomy in
        decision making and practice.

5.   The profession as a whole has a code of ethics
        for practice.

Following Weber, Etzioni (1964) sees modern society as an organizational society: "We are born in organizations, educated by organizations, and most of us spend much of our lives working for organizations." His focus is the relationship between the organization and people in the organization. The organisations that nurses had to fit into were hospitals, and in this period, training was conducted in hospital settings. This location where nurses trained and worked also caused conflicts in later years.[19]

Use of such a discourse to prove whether nursing was a profession was problematic in several ways. Etzioni did not mention authority (although it is implied in point 4) or its relationship to how status was defined in such a system of setting order. Although nurses were believed to work with a sense of 'calling', this was not viewed as a sufficient basis for a profession. Nevertheless, early engagement with these discourses meant that early attempts at proving professional status were done through proving one's legitimacy as a profession as set out in such writings. Also by locating such portrayals in nursing textbooks, the authors of such texts are promoting this point of view to people learning about nursing. Achieving professional status for nurses was viewed as necessarily gaining a discrete body of knowledge and autonomy for nursing and its practitioners.[20] Autonomy implies self-determination and nurses were challenged repetitively to prove this as a part of their attempts to gain status as professionals in that society.[21] Parker (2001, p. 41) explains autonomy is:

> a goal of personal or group development with its basis in a personal consciousness of the self (individual or group) which allows for the maintenance of integrity as the individual's or group's belief are enacted, even when freedom is diminished or absent.

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[19] See the discussion in Chapter 3 and 5.

[20] For example, Johnson (1959) discussed the construction the body of nursing knowledge in nursing in relate to scientific knowledge of nursing. See the discussion in Chapter 4, p. 120.

[21] See more discussion in Uncertainty and risk in this chapter, page 44.

Discussion of autonomy in nursing also implies that nurses as professional group were gaining the power to decide their direction.

Establishing influential relationships between nursing and society

Using debates about the ideas of professions and applying these to nursing, nurses tried to achieve professional legitimacy through means such as having a theoretical body of knowledge, professional education, a code of ethics, and so on. However, the issue was that nurses were not educated in a place that would accomplish many of these criteria. The students who were training to be a nurse were called students nurse and nursing training was still based on apprenticeship, well into the 1980s in Australia. [22] Nurses started to demand a place separate from hospitals, to learn nursing. [23] It was significantly important to have the place to study and situate nurses as learners, because a hospital where nursing and nurses was governed by medical doctors was not viewed as appropriate to improve their professionality. In line with the thinking of the time, self-governance was essential to gain recognition of nurses' authority over their own practice. Self governance meant control of education of nursing students, establishing control over their professional governing organisations, professional knowledge development through theory and research, as well as creation of practice standards. Nurses utilised theory of examples other disciplines such as sociology, medicine and so on to develop a process that would create recognition of the professional status their discipline and practice. Having and deciding what would be termed nursing's own practice area, an expectation defined in Etzioni's classification of profession, also made professionality stronger with a developing sense of responsibility and accountability in nursing.

Accountability and responsibility in the nursing profession

According to the latest competency standards (ANMC 2006a), accountability for ones professional practice is a competency domain. In the section 2.5, it states, "[a registered nurse] Understands and practices within own scope of practice – demonstrates accountability and responsibility for own actions within nursing practice" (p. 4). In this description, a nurse knows what she/he practices and the

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[22] There was small number of college-based nursing schools who recognised their students as nursing students.

[23] Detail will be discussed in Chapter 3.

meaning of it. The current practice of nurses is explicit and explainable. I will now explore how the concept of accountability and responsibility developed in nursing professionalisation discourses.

Was there accountability and responsibility in the sense of calling?

When nurses worked with their sense of calling, responsibility was not questioned. Responsibility is created when some tasks are set to be carried out. Within a task framework, responsibility is accomplished. Responsibility was based on their calling, which also associated with the religious sense of nursing. Therefore, responsibility existed in the relationship between the nurse and God rather than in nurses. Or if nurses were regarded as a handmaiden for doctors' convenience, following directions from medical doctors and accomplishing set tasks was their responsibility. Moreover, a sense of accountability did not exist in this atmosphere, because accountability is explained only when the relationship between a profession and society is established in a set of codes, regulations and shared understandings.

Seeking accountability and responsibility

There is no evidence of nurses mentioning terms such as accountability and responsibility in 1960s. Rather, nurses realised there were deficiencies that led to their not being recognised as a profession. Nurses believed that the separation of the educational setting from the hospital was important for professions to establish self-regulation. Having a discernible disciplinary area and location would help to establish professional status. Although nurses had been gaining practical medical skills with the development of medical technology, the autonomy of nurses' work remained limited (Wolf 2006, p. 306). How nurses cared for patients was still governed by medical doctors and nurses did not possess their own decision-making authority. This dominant discourse suited those who are believed that characteristics of the 'classical' professions were central to the function of professionals in society. In this phase, the professional definition transformed from professionals being defined by society to professions being innovative and collaborating with the society in a process of self-definition.

Establishing accountability and responsibility

The next terms I turn to are the terms 'accountability' and 'responsible' coming into use in the texts of the early 1980s. In the 1984 RANF's 'Nursing' a statement described, "…nurses will honour society's trust and be accountable for the quality of the nursing services provided" (RANF 1984). Furthermore, the 1989 *ANF Nursing in Australia: a national statement* described (ANF 1989), "The nursing profession is accountable to society for the provision of high quality and cost effective nursing services. Nursing demonstrates this accountability by continually evaluating nursing against the profession's standards…" the nurses' accountability in this statement is bound with their actions. In the 1990 competency standards (The University of Queensland Assessment & Evaluation Research Unit Education Department 1990), the term was used in the definition of the Registered Nurse (1990, p.65):

> The Registered Nurse is the first level nurse who is licensed to practise nursing in the field/s in which he/she is registered without supervision, and who assumes accountability and responsibility for own actions. This nurse is also referred to as the professional nurse.

There is an assumption that competent nurses know what to do, working without supervision, accountable and responsible for their practice. Their actions in practice are now embedded with nursing knowledge and they are supervised by their thinking. Thus, by 1990 the nurses' action and thinking is no longer based on a sense of calling, some remnants of which are still seen in the 1984 statement "honour society's trust", or supervision by others. It is based on their professional characteristics as a registered nurse and who is regulated as such. The other shift from 1984 is from nurses as a group being accountable to each individual being accountable in 1990. The 1990s statement shows that nursing gained control over its practice, which also implies possession of power over their definition as a profession.

Collegiality

'Collegiality' is shown by Barber (1985, p. 218) using a neo-functionalism view, as a political weapon:

> Collegiality, both formal and informal, has been used to oppose reforms proposed by non-professionals through the political process, very often successfully, as in the matter of so-called "socialized medicine"…

Barber's discussion pointed out how professionals exclude non-professionals. Collegiality established segregation in terms of particular kinds of professional interests and characteristics. In the nursing profession, only registered nurses can share their knowledge and practice. The term collegiality is not explicitly described in the competency standards (ANMC 2006a). However, 'collegiality' is implicit in the following description - "The Registered Nurse contributes to quality health care through lifelong learning and professional development of herself/himself and others" (2006a, p. 3). Nurses belong to Colleges and Professional Societies which interact based on shared interests, and 'collegiality' they may also exclude non members who are nonetheless RNs.[24] Nurses believed that this process aids the professional development of themselves and other nurses.

The negative productions of collegiality

Illich (1977, p. 16) argued that professionals disable relationships by ignoring human needs. Barber and Illich highlight problems arising from segregation of professionals such as self-regulation, medicine's monopoly over clinical decision-making, and so on (Germov 2005, p. 296). Professionals obtain their right to make decisions by being accredited as professionals and it is clear that the knowledge gap between the clients and professionals are based on level of experience and education. Thus, a difference in status between them clearly exists. The term collegiality that Barber referred to is one way of increasing the imbalance between professionals and non-professionals. What makes this problematic is that the power may not work in the clients' interests or health. There is control over access to knowledge and also limits on consumer knowledge as Barber's notion of collegiality infers.

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[24] For example, College of Mental Health Nursing has defined the educational criteria required for status as a MHN. These criteria then influenced design of post-graduation university courses.

Sisterhood as collegiality

The current definition of collegiality is defined in terms of the power relationship between professions and non-professions. In the present sense, collegiality exists as a part of professional development. Collegiality was thought of differently when nursing was believed to be based on a calling; it existed in individual nurses. Women in religious groups formed sisterhoods (Dingwall, Rafferty & Charles 1988, p. 29) to look after the sick and poor in the community. Although this context of sisterhood means the group worked within a religious belief system, the group shared the same vocation which existed in the individual nurse. It was the same in during hospital training. Nurses lived in the nurses' home, shared their lives and helped each other.

However, at present nurses have replaced the idea of vocation and sisterhood with collegiality as supporting development of others as a way to achieve professionality. Not many nurses live together at nurses' homes and nursing students belong to a practice group to share and discuss their practical experiences to reflect and improve their professionality. Separating the place where nurses lived, worked and trained brought the opportunities for nurses to professionalise individually. Thus professionalisation in nursing has brought about a shift in focus from the group to an individual professional.

Uncertainty and risk in professions

In Chapter 1, I described how in the 1950-60s, uncertainty in nursing existed as to whether a nurse would ever be accorded professional status or not. Nurses decreased this uncertainty by utilising professionalisation discourses such as Etzioni's nursing professionality is now established. However, this has not resolved uncertainty about professionality that arises from things such as deficits in professional knowledge, behaviours or skills. Moreover, the resolution of this uncertainty remains within the control of nurses themselves, not relying on societal values to overcome or make a difference. While controlling these uncertainties is important for clients who are to benefit from nursing care, their recognition of status is no longer central in this project. This uncertainty is an uncertainty that resides in the practice of many other professions.

Barber explained that uncertainty in practice is caused not only by the lack of scientific evidence but also by "an ideological justification of a variety of medical practices". In other words, uncertainty does not only mean uncertainty about the state of a disease (and clients' health status) based on evidence. It also means that much of the rationality attributed to medical certainty in practice comes from the use of ideology or routine to justify a practice. Barber cites Fox, 'Doctors are specialists in uncertainty' and furthermore:

> …then they need practically unlimited autonomy to face this hazardous situation. But their autonomy is often at the expense of the autonomy of others, both their subordinates and their patients (Fox 1957, p. 219).

Paradoxically, the degree of uncertainty increases as the degree of autonomy rises. What is the relationship between autonomy and uncertainty? Within uncertain situations, an autonomous professional attitude helps to manage any uncertainty in practice. For example, professionals' autonomous activities such as their ability to make sound decisions, decide on service fees and the cost of their work justifies the certainty about client's conditions (Germov 2005, p. 292). Moreover, ethic-legal practice requires professionals' behaviour in practice to be based on their ethical manner. In other words, all professions include these manners as regulations. Seeking and defining the professional boundary also requires professionals to take risks when being autonomous. However risks taken in uncertainty are expected to be minimised and eliminated by professionality, which is made up of in-depth knowledge, skills and behaviour that define a particular profession's practice area.

Uncertainty and nursing profession

How does the uncertainty and risk control affect the understandings about the nursing profession? Having described how uncertainty is controlled in professional training in Chapter 1, the situation of uncertainty requires professionals to be knowledgeable so as to resolve any uncertainty. This concern with 'uncertainty' has been a key issue in nursing in recent decades. In the early stages of the project of professionalisation, nurses were merely recognised as the doctors' hands. Nurses did not need to judge the situation in order to follow doctors' orders. The concept of uncertainty did not exist for individual nurse in this period, but was dealt with

structurally that is, by close supervision and well delineated hierarchies of practice. With the recognition of nursing as a profession, however, uncertainty as a state of being in nursing has become more visible. This led to changes in the way nurses were trained and taught. It reflected changes in understanding about health care, in which, for example, patients were more knowledgeable about their health and expected to be informed and to be involved in health care decisions.

Light (1979) analysed uncertainty in professional education, especially in medical education from various aspects such as knowledge for practice, instructors and diagnosis. Furthermore, he claims that training is important as a control of uncertainty. However, Light's (1979) central argument is that there is too great a control of uncertainty:

> Thus in gaining control over their work by acquiring a treatment philosophy and exercising individual judgement without question, professionals run the danger of gaining too much control over the uncertainties of their work by becoming insensitive to complexities in diagnosis, treatment, and client relations…The goal in professional training should be to learn *tempered control*, that is, sufficient control to overcome the uncertainties of practice so that decisions can be made, but tempered by the continued acknowledgement of those uncertainties and human error (Light 1979, p. 320).

If the objectives and purposes in professional training, as Light outlines above, were to be taken up in nurse education then this could make a difference in how control of uncertainty is undertaken during training. The essential difference between nurse training and nurse education is their status as nursing students in nurse education and that the process of learning is more considered.[25] It can be said that the recent nursing professional interest in 'evidence-based nursing' also represents a strategy for reducing uncertainty in the professional education of nurses. The use of the 'nursing process' is one of the earliest tools developed to deal with uncertainty. Use of both evidence-based nursing and use of the 'thinking tools' of nursing such as nursing process, run the risk of creating too much certainty and the loss of Light's 'tempered control'. This will be discussed in more depth in Chapter 4.

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[25] Details of this will be discussed in Chapter 5.

French (2006) recently investigated how nurses perceive uncertainty in their work. From observation of nurses' clinical practice, French categorised various levels of uncertainty. As uncertainty exists at various levels, French claims that it is more fruitful to consider the methods for handling this uncertainty. French (2006, p. 251) wrote:

> While this is an untested assumption, evaluating the impact of methods to increase the demand for information (such as the opportunities for comparison against others in clinical networks or by bench-making) may be a more fruitful avenue of investigation than current strategies that focus solely on the provision of information.

There was no such deliberation possible in nurse training that occurred in hospital apprenticeships where there was a focus on the training of skills. Increasing training of skills in the hospital system became more difficult due to requiring more time and taking student nurses away from wards in blocks and, study days. Nurse education in the hospital system became too expensive. Professor Sioban Nelson explained in the radio program in this situation (Phillips 2007):

> …[since the 1950s] following breakthroughs in science, around pain and anaesthesia and the ability to stabilise patients…Now that kind of patient needed a highly educated nurse, and a highly experienced and well-skilled nurse. So the student nursing workforce became increasingly inappropriate, plus the whole cost of education when you're starting to meet standards of well-developed curriculum where you had to rotate students in all number of areas…When the hospitals started to cost that…they realised that it actually wasn't worth the money for them to be funding a lower qualified person…

Uncertainty in nursing training in hospitals was controlled as the student nurses' tasks were allocated and supervised. The tasks such as basic care did not require much decision making. However, demand for requiring more highly skilled and educated nurses in hospitals required the nurses to be knowledgeable and responsible for their decision making in nursing care. Uncertainty became more visible when nurse education occurred in the university or college setting as each nursing student was expected to be educated to think autonomously as the professional nurse they were to become. It is an assumption of this study that study of the design and development of nurse educational curricula will indicate how such a process took

place and what processes it used in pursuit of its strategy for professional recognition for nurses.

Uncertainty in nursing and medicine differ in terms of how uncertainty about knowledge is framed. Medical practitioners possess in-depth knowledge relating to diseases. The assumption for this focus on this knowledge in particular is that medical practitioners' uncertainty is controlled by this knowledge framework. On the other hand, nursing struggled to establish control over its professional knowledge base well into the mid-1980s. Since then, the nursing profession has established regulatory, structural and professional control over what counts as nursing knowledge as well as establishing its boundaries. The ability to control uncertainty implies that nurses gained the right to autonomous practice for nurses. For example, in the development of standards for nursing practice, the nursing code of ethics and the continuing evolution of competency standards, nurses were indicating how they were developing tools and evidence to deal with uncertainty in nursing practice. Nurse leaders sought to develop strategies that had the potential to resolve both questions of professional status and the control of uncertainty and risk in practice. There was an accompanying shift in strategy at the individual level in terms of dealing with uncertainty in nursing practice. There was a movement toward nursing self-regulation in Australia, first reported in 1988. A government report *Self-regulation in Australian industry and the professions: report by the Trade Practices Commission* (Mc Comas et al. 1988)*,* described how the benefit of the introduction of self-regulation lay in, "including higher ethical standards of conduct enhanced business efficacy and overall consumer benefit" (McComas et al. 1988, p. 1). This report is particularly relevant in industries and markets, in which the government has an economic interest so that the self-regulation introduced into the business arena aimed to promote economic effectiveness. This concept is based on the strategy of governmentality to make professionals accountable for themselves and to police their members for the government (Barry, Osborne & Rose 1996, pp. 10-1). In this report, self-regulation was defined as (1988, p. 2):

> …the adoption of codes of practice embodying mutual obligations by competing members of an industry or profession. Such codes, usually adopted and administered as an industry initiative, normally complement both federal and State regulations.

As I described previously, the government's purpose in introducing self-regulation was to change the Australian economy so it was more competitive in global markets. This impetus for self-regulation diffused through to other areas of government. From 1988-1998, the concept of what counted as self-regulation in the nursing profession changed as the profession developed the texts that were to signal its ability to self-regulate according to government policy and strategies. Since then, the nursing profession has taken self-regulation to mean accountability of the nursing profession (Rose 1996, p. 53).[26] In this sense, the independence of the nursing profession from other professions has been established. These themes are analysed in more detail in Chapter 3.

Body of knowledge

When nursing was not recognised by society as having professional status, and its own ideological belief system held that their professional status relied on their calling and vocation to nursing, nursing knowledge, such as it was, was subordinated to medical knowledge. Such a belief system led to the further belief that nurses' experience and moral behaviour was also considered an important element constituting nursing practices. Nelson described the relationship between moral behaviour and nursing practice, "The function of training was to develop personal attributes in the nurse" (2000, p. 162) and "It is undeniable that moral training in the development of certain personal attributes was as much a function of nursing training as the acquisition of other skills" (2000, p. 162). Thus nursing training emphasised attainment of moral behaviour rather than focusing on knowledge underpinning and supporting nursing practice.

The subordinated knowledge from medicine was disease-centred knowledge focusing on how nurses should observe the diseased body for medicine. Such

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[26] This professional view is based on Weberian models of professional status.

knowledge was usually provided as a list describing types of observation required and the actions of nurses as a duty to medicine.[27]

It is only a half century ago that the nursing profession started to build its own recognisable nursing knowledge. For example, in the USA the first discussions of nursing as a science (Johnson 1959) and development of nursing theory, such as by Peplau (1988; originally written in 1952) was seen in the 1950s. Johnson (1959) argued for nursing's applicability as science.[28,29] It was argued that for nursing to be considered a science, nursing practice needed to have a base in a theoretical framework or theories. This motivated nurses in their development of theories such that nursing could be acknowledged as science. In this process and professionalisation strategy, nursing theory development began by theorising the relationship between nurses and patients. This strategy was aimed at detailing what could be considered to be unique to nursing, rather than the subordinated knowledge that came from following medicine.

Technical rationalities and nursing professionalisation

One of the external influences on nursing professionalisation is scientific development. This development brought with it partial visibility. I cited Foucault's work in Chapter 1 and explained that medical doctors can now name the abnormality with the body that they could not before anatomical and pathological clinical knowledge development occurred. Clinical physicians were able from this to diagnose abnormality in the body and nurses were able to share in this knowledge. With the power to diagnose by using medical technology, the diseased-body was made understandable by rational means and any abnormality in the body could be named, categorised and used to define patient situations. It is argued that this medical technological rationalisation brought with it the loss of the individuality of the patient. The medical doctors' interests were to seek out abnormality in the patients'

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[27] This medical-oriented observation will be discussed in more depth in Chapter 4.

[28] The detail will be discussed in Chapter 4, page 120, 'Nursing demanded to be recognised as a 'science'.

[29] Although it could be argued that Nightingale's Notes on Nursing (Nightingale 1992, p. 69) represented nursing knowledge, there was little systematic development of nursing knowledge till the 1950s.

body, not to know about the patients. Nursing, subordinated to medical knowledge, was influenced by such rationalities. Nurses used this scientific knowledge system to be recognised as a group of health professionals, and were provided with basic medical scientific knowledge to practice effectively in caring for patients in hospitals (see Chapter 4). For example, the discourses of nursing process showed such an application of technical rationality in nursing and will be discussed in greater detail later in the thesis.

Nursing as a knowledge-able profession

The definition of professionals is not only decided by society but also by professionals themselves. Nursing, as a professional group, and nurses as individuals own its unique knowledge and use this to further the development of the profession. Rafferty (1996, p. 7) wrote in *The Politics of Nursing Knowledge* about the communication process of nursing leaders borrowing ideas from authorities such as the government, professional councils and so on to form nurse education. She described several categories of cognitive approaches to nursing knowledge development. Firstly, assimilationist; which tries to use the established disciplines and their knowledge as a way to clear nursing problems; separatist, which tries to create new characteristic knowledge and to differentiate this knowledge from other disciplines to present knowledge as unique to nursing (1996, p. 7). Nurses used the assimilationist approach in nursing and medical knowledge subordinated nursing as a discipline. For example, this approach was used in the exploring the thinking tools such as nursing process, problem-solving approach and clinical reasoning. Some tools are assimilationist as they have already been used in other disciplines and nursing used them to be seen as 'scientific'. The second approach is separatist approach. Nurses tried to establish the uniqueness of nursing knowledge by differentiating nursing from other disciplines. For example, nurses used sociological knowledge to gain professional status and established the relationship between nursing professionals and society. The argument for nursing professional role development, for example the Nurse Practitioner role is supported by this approach. Nursing theorists' work also attempted to develop nursing knowledge by establishing the unique body of knowledge. Although Rafferty described two ways to approach knowledge development in nursing, it is difficult to separate out the approaches.

Nurses and nursing have utilised both these approaches in nursing knowledge development. Both approaches have been used to reduce uncertainty in nursing.

This discussion leaves unanswered questions which continue to challenge nursing[30]: Is nursing a copy of other disciplines? Is nursing a unique discipline? The discourses on the thinking tools of nursing will be discussed in Chapter 4 and how these tools were used in the curriculum and nurses used will be discussed in the following Chapters 5, 6 and 7.

Conclusion

This chapter has provided the foundation for understanding how the concept of profession was mobilised to improve the status of nurses. A genealogy of the discourses of professionalisation, by investing in the characteristics of what counts as a profession gives insight into what constitutes beliefs about what represents a professional. The range of languages used to determine the characteristic of nursing professionals shows that nursing was influenced by other disciplines, such as medicine and sociology, to demonstrate its right to be called a discipline and a profession.

Taking advantage of the changes occurring in society, nursing employed many strategies to obtain recognition as a profession. The right to define and govern a profession, gained late in the 20th Century, was supported by many of the social influences that brought significant change for women and minority groups. Continuous changes in the processes of government have led to nursing's ability to govern itself and define what the nursing professional is. As Rafferty pointed out, nursing borrowed language from other disciplines to create its own (1996, p. 7), the texts show this borrowing-utilising process. In next chapter, I will focus on the role of nurses from a social perspective and analyse how the interaction between nurses and society has altered throughout the latter part of the 20th Century. In the analysis process, I will utilise intertextuality to see how nursing professionalisation discourses

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[30] For example, current debates about the nurse practitioner role and the move to introduce physicians' assistants into Australia.

are interpreted or reflected in role statement texts.

CHAPTER 3

NURSING PROFESSIONALISATION IN AUSTRALIA

Introduction

I described the discourses of nursing professionalisation in Chapter 2. The characteristics of professions indicated changes in what constitutes the concept of professions and how nurses used these discourses to legitimate themselves; as a result of gaining social recognition as a profession. Although the current professional characteristics are described in the competency standards (ANMC 2006a), the historical nursing professional characteristics remain in the texts such as nursing textbooks, organisational statements and institutions. In this chapter, I will analyse the discourses in these texts that have shaped and formed the agenda for the professionalisation of nursing in Australia and internationally.

While I approached on the discourses, I asked the following questions as the basis of the analysis; 'how do these texts express change since the 1950s?', 'what kinds of words have been used historically to describe nursing and the role of nursing?' Moreover, it was essential to consider 'who' and 'how' was concerned and saw the role of nurse. For example, who wrote the texts and what were the intentions to write. Considering these questions to the texts is important while I analyse texts as discourse. As I have argued in Chapter 2, legitimatising the nursing profession is not carried out only by social influence, but also by nurses themselves. Through an analysis of the texts, I have categorised role statements and nursing definition since the 1950s into four phases. The 1920s-1950s was an important phase that included the establishment of the Nurses' Board and the nursing legislative movement. I have named the four phases: 'The role of nurses defined by others'; 'A nurse as a skilled and good person'; 'A nurse as a member of health care system'; and 'A nurse as having a unique role in internationalised society'.[31]

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[31] These four descriptions do to some extent overlap. The texts used for this analysis are listed in Appendix 1.

Phase 1: The role of nurses defined by others

The role of nurses was not well documented up to the 1950s in official documentation. The role of nurses was not defined in the social sphere but in the personal sphere. Nurses were considered as doctors' 'hands' but this understanding was complicated by the progress in medical technology since the World Wars. Nevertheless, there were movements that defined nursing through the establishment of professional organisations such as the Nurses' Board and the Nurses' Association in Australia.[32] I focus on the period after the 1950s although these professional organisations were established prior to the 1950s. The early history of the professional organisations is included briefly as it provides background for developments from the 1950s.

Legislation in the 1920s to maintain the nurse workforce

Two influences helped establish nursing legislation. One is the two World Wars and the other is changes in nursing in the United Kingdom. Firstly, due to the greater recognition of the importance of nurses during the First World War, there was a need to sustain nurses' numbers and availability for the workforce.[33] In this sense, at the start of the registration system the purpose of establishing nursing legislation emphasised workforce control rather than the professionalisation of nursing. World War I promoted the need for distinguishing nurses who were trained appropriately and those who were not. White (1993, p. 2) put it this way:

> During the war and in the immediate post-war period the perception of the association between registration and professionals status became more apparent as nurses attempted to distinguish between trained nurses and those not trained or inappropriately trained during the war.

Moreover, the influence of Britain needs to be considered, particularly through the Registration Act in 1919 in Britain (Durdin 1991, p. 89). The background of passing this registration was the war. White (1993, p. 8) also commented:

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[32] The respective predecessors of these organisations were: The Royal British Nurses Association (established in 1901) and The Australasian Trained Nurses Association (ATNA), SA branch (formed in 1905).

[33] In contrast to this view, Dolan, Fitzpatrick and Herrmann (1983) wrote in the case of the U.S. that it was "essential that nursing organizations protect the public from unqualified nurses" (p. 272). This led to accreditation of schools to prepare curriculum.

> The value of the services nurses rendered during this war is well documented in the professional literature, but it was also recorded as a justification for the granting of professional status during the second reading of the Bill in Council. The support for professional status for nurses during the war were major factors in the achievement of State Registration of Nurses in Great Britain.[34]

The emphasis on registration became equated with professional status. It was however more to do with regulation rather than nurses achieving real control over their own education and practice. The influence of Britain persisted after the formation of the Commonwealth of Australia in 1901 and continued through the registration system developed in the 1920s.

Registration system for whom?

Following the British movement, the registration system in South Australia began in 1920. South Australia was the first state to establish a Nurses' Registration Board in Australia. The role of the board was to be "responsible for the general training and examinations of all trained nurses registered in this State" (The South Australian Trained Nurses 1989, p. 203). White (1993, p. 9) explained that the establishment of the Nurses' Registration Board in South Australia was straight forward and there was no lobbying from the nurses. The Royal British Nurses Association had been established in 1901 and this influenced the South Australian establishment. White (1993, p. 9) described this as follows:

> RBNA [Royal British Nurses Association]…as a direct result of an invitation to the Matron of the Adelaide Hospital to form a South Australian Branch of the parent organisation in the United Kingdom, which is indicative of the strong ties which existed between the motherland and the colony at that time.

The British precedent ensured that the Nurses' Board in South Australia was established smoothly. However, the process of establishing the board is debated, in terms of nurses being professionals. In this context, Durdin (1991, pp. 89-90) wrote:

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[34] McGann (1992, p. 6) wrote that the battle over registration lasted for 32 years.

> …the first report of movement in this direction came in November 1919, when a member of the Legislative Council asked the Chief Secretary to consider the introduction of legislation to 'protect the status of nurses'. The newly formed South Australian Hospitals Association, comprising representatives from each of twenty country hospitals which were partly self-supporting but dependent upon the government for an annual subsidy, actively promoted this legislation. The Hospitals Association did not claim to have particular concern for the status of the nursing profession; rather, in legislation for the registration of nurses it saw opportunity to overcome staffing problems in country hospitals.

Durdin highlights there were two purposes of the legislation. One was to protect the status of nurses and the second to assure the nursing workforce. The first reason was stated by the Legislative Council and the second was stated by The Hospital Association, meaning that they saw different reasons for the nursing legislation. The Hospital Association (consisting of medical doctors and hospital administrators) did not talk about protecting the status of nurses, but did mention the shortage of nurses particularly in rural areas where hospital could not offer registration without experience elsewhere.

The crucial issue here was that the legislation limited who could be a nurse. The benefit for The Hospital Association regarding the nursing legislation was to accredit country hospitals as training hospitals. The Hospital Association tried to resolve the shortage of nurses by accrediting hospitals as places providing nursing training. However, the context of training courses and requirements for entering such courses was controversial. The Hospital Association needed to recruit as many nursing students as it could enter the workforce. They insisted on working conditions, pay and longer hours to maintain the workforce situation throughout the country. In the country, it was difficult to recruit if the requirements were stricter than this.

On the other hand, the Chief Secretary insisted that the purpose of legislating for nursing was to improve the status of nurses. White (1993) stated that the establishment of the Nurses Board had been easy. There was an unequal power relationship between the medical doctors and hospital administrators on one hand and the nurses on the other:

These issues, however, did not fall within the remit of the Nurses Registration Act and thus were not addressed by the NRB [Nurses Registration Board of South Australia]. The responses of the NRB to broader issues including the support registered nurses to charge fees and the right to sue for fees…These issues were the source of much debate as the representatives from the country areas did not wish to include such a restriction in the Bill. They anticipated that such matters would have significant impact on the practices of unregistered nurses, in particular, in many country centres…it is surprising that both the Medical and the Nurses Registration Acts permitted non-registered persons to continue to practice. The Bill passed through Parliament with very little further debate and was gazetted as the Nurses Registration Act in November 1920 (White 1993, pp. 11-12).[35]

Furthermore, Durdin (1991, p. 90) found that:

Through 1920 preparation for presentation of the Bill continued. There is no evidence of a nursing lobby…In the legislative Council D.J. Gordon expressed disappointment that the main objective of the Bill seemed to be overcome shortages of staff in country hospitals; he was concerned that the status of nurses might thereby be lowered. He argued strongly for legislation which would advance the high standard which had already been demonstrated by South Australian nurses in their wartime service, and urged that nurses be appointed to the majority of positions on the Nurses' Board .

After the First World War, the shortage of nurses became severe and the need to solve this issue became a priority.

What did the legislative movement imply?

Durdin (1991, p. 90) and White (1993, p. 9) wrote that there was no record of lobbying of nurses in South Australia and the process was easy compared to the other states such as New South Wales and Victoria. What does this mean? Decision-making in the legislative process was undertaken by hospital members who were administrators and medical doctors; they decided how many and what types of nurses the hospitals needed. Nurses were not expected to state their views about what they wanted to do, although the nursing legislation was their main concern. Nicholson (1998, p. 77) and White (1993, p.12-3) described how when the Nurses Registration Act was passed, nurses expected their status to be protected and promoted:

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[35] The titles such as The Nurses Board and Nurses Board were used until The Nurses Board is labelled 'Nurses Registration Board' in 1947 (White 1993). I used the title according to the period that the term was used.

However, this legislation did little to realise these aspirations as, instead of giving nurses more decision making autonomy, it shifted occupational control away from them and vested statutory power with in the NBSA [Nurses Board of South Australia]. The composition of the new Nurses Board reflected the lack of power held by nurses. There were seven members: two representatives from the South Australian Hospital Associations, two lay and a representative from a nursing association. The NBSA was therefore controlled by medical staff and full time public servants rather than nurses (Nicholson p. 77).

Although the Nurses Registration Board was established in South Australia, its role was to control nursing workforce, as it still does. Promoting nurses' status was a second priority of the NBSA, in terms of improving the nursing training system with workforce control the first priority. There were nurses on the Board but they were ineffectual. According to Nicholson (1998), "This meant that nurses still did not exert control over nursing affairs nor did they have complete authority over the education of nursing students". Nicholson (1998, p. 77) continued:

it is not surprising to find that by 1946 nurse education within SA had stagnated. Indeed, the NBSA approved nursing training scheme had remained substantially unaltered since it was first established in 1921.

Consistent with Weber's thesis about professions generally, nursing was not considered as a profession and medical doctors and hospital administrators defined the nurses' role through legislation as subordinate. Although there were expectations from the nurses that working conditions and the training system would improve, nurses did not take action in regard to their being recognised as professionals. The Nurses Registration Acts of 1920 and 1922 described the Board's authority and duties as follows:

The Board shall have and may exercise and discharge the powers and duties conferred or imposed upon it by this Act, and in particular the following powers and duties:

I.   To hold examinations (including preliminary entrance examinations), to appoint examiners, and decide upon their remuneration:

II. To decide upon the places where, and the times when, examinations are to be held:

III. To issue and cancel certificates of registrations:

IV. To approve of any institution as a training school, and at any time to cancel any such approval:

    V. To publish periodically a list of the institutions approved by
       the Board as training schools:

    VI. To take proceedings against persons guilty of offences
       against this Act:

    And generally to do anything necessary for the due and proper
    carrying out of the provisions of this Act.

Although the role of the Board is clearly specified, the control of the workforce was not clearly described in the Act. The function of the Board is limited to the accreditation of the nursing training course and ability to practice as a nurse. Because accreditation was closely connected vis-à-vis the hospital and training course, the responsibility of the Board is enormous.

However, the function of protecting nurses was not done by the Board. These functions (i.e. education and nursing practice) were dealt with by other nursing organisations. The earlier phase of strengthening professionality shows that the appearance of authority to control the profession as described in Chapter 2, was consistent with Weberian theory. In South Australia, various organisations shared similar roles until the 1970s.[36] Although the matter of registration was not controlled by nurses in terms of decision-making about nursing training courses up to the 1970s, the preparation for professionalisation was underway, as for example, the colleges for nurses' continuing education started at the national level in 1949.[37]

International movement regarding nursing legislation

The World Wars created opportunities for advancement of nursing in the 20th century. The International Council of Nurses had been established for the nursing profession

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[36] The history of nursing in South Australia from the 1950s to 1970s was the era of establishing and dividing organisations' role. Specifically, industrial and professional development issues in nursing were the key to promoting nursing as a profession. The Royal Australian Nursing Federation had a Sister Tutor section, played an important role in planning the nursing training course in South Australia (Durdin J, 2006, pers. comm., 28 March).

[37] Nursing profession organisations such as the New South Wales College of Nursing in 1949 and College of Nursing, Australia in Melbourne were established. These colleges taught postgraduate education for registered nurses. The education of nursing professionals begun in the 1950s, however the students who entered the colleges were still limited in number and more emphasis was placed on educating leaders (Durdin 1991, pp. 243-249).

in 1899. Its first conference was in 1901.[38] International communication among the member countries accelerated the establishment of legislation for nursing professionals.

The legislation movement in South Australia was influenced by Britain during the 1910s and the 1920s, and the legislation movement was also international. Nursing Acts were passed in 1914 in Canada, Germany, France, Japan, United States, and other countries. However, before the international movement for nursing professionalisation, the Second World War broke out and influenced deterioration in nursing professionalisation. During the Second World War, the nursing shortage was of great concern and the requirements to be considered as a nurse were lowered (Summers 1993). After 1945, nursing again worked toward professionalisation. Although renewed efforts to re-establish nursing as a profession were required, the experience of the War, "had given nursing a new impetus" (Durdin 1991, p. 156). Moreover, the World Wars had accelerated the development of medical technology. This was an important influence on the nursing profession in defining its role.

International movement concerning the role of nurses

Andrell (1957, p. 19) addressed the role of nurses in health care in *International Nursing Review*. She explained that health and social welfare workers were considered to be health professionals. Andrell (1957), however, states, "what appears to make the nursing profession different from its younger sisters and brothers, is the fact that the work is comparatively more complex and therefore more difficult to define". The need to define nursing as a profession was urged and the World Health Organisation Expert Committee also tried to define 'a nurse' to set an international standard. The first of many sessions on this theme was held in 1950 and in 1956 the role of nurse was defined at the 9th World Health Assembly. Five functions of professional nursing were listed as follows (INC 1956, p. 11):

> 1. Giving skilled nursing care to the sick and disabled in accordance with the physical, emotional and spiritual needs of the patient whether that care is given in hospitals, homes, schools or industries.

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[38] Australia participated in the conference.

2. Serving as a health teacher or counsellor to patients and families in their homes, in hospitals or sanatoria, in schools or industries. Because of her extensive and intimate contact with patients and families, she [sic] usually has the confidence of the family and is in a strategic position to put scientific information into simple language which they will understand, accept and put into practice.

3. Making accurate observations of physical and emotional situations and conditions which have a significant bearing on the health problem and communicating those observations to other members of the health team, or to other agencies having responsibility for that particular situation.

4. Selecting, training and giving guidance to auxiliary personnel who are required to fulfil the nursing service needs of particular patient and assigning personnel in accordance with the needs of that patient at a particular time.

5. Participating with other members of the team in analysing the health needs, determining the services needed, and in planning the contraction of facilities and the equipment needed to carry out those services effectively.

These functions emphasise a nursing task perspective. For example, 'Giving skilled nursing care' and 'making accurate observations of physical and emotional situations and conditions', are descriptions based on what nurses did at that time. The nurse's observations are interpreted by others. Moreover, the description of 'her [sic] extensive and intimate contact with patients and families, she usually has the confidence of the family and is in a strategic position to put scientific information into simple language' puts emphasis on the art side of nursing such as personal and emotional aspects. There is no description of nursing that is based on the science aspect of the nursing discipline other than 'accurate observations', or managing the care of a client/ patient.

This was the first time that nursing had publicly been described internationally in a nursing journal. This description does not include the responsibility of nurses as a profession, in other words, what nurses should do as a profession. Nurses became more responsible in terms of dealing with technical skills that used to belong to doctors, but without the depth of knowledge to use the technical skills safely.

Australian concerns and arguments

As the population in Australia grew, the demand for health care increased. The number of hospitals over Australia increased and with technological and scientific developments, more patients were institutionalised than ever. As the number of hospitals increased, so did the number of nursing staff. Those who wanted to be a registered nurse in the 1950s went to a training school based in a hospital. The nursing care system in the hospitals at this time was generally task-based, with procedures such as vital sign monitoring, previously the role of doctors, being taken over by nurses as medical technology became more complex.

The role of nurses started to be discussed internationally and in Australia. In 1954, Professor Robson (1954) a professor of medicine at the University of Adelaide presented 'The need for revolution in the nursing profession' in the Fifth Annual Meeting of College of Nursing, Australia at Bonython Hall, Adelaide. In the address, he mentioned that given his position as a medical doctor he knew about nurses after working with them for a long time. However, he acknowledges the difficulties faced by nursing as different to those of medicine:

> I have dealt with this condition at some length because I now propose to talk to you about the "Need for a Revolution in the Nursing Profession". I implore you at once to put the prophylaxis against Verbiosis into operation. You should be asking yourselves "what right has this man to be talking about nursing?" and "What value would anything he says have?" You might reason thus: "He is a University professor". "That means very little really- professors are very apt to be rather fond of pronouncing on all sorts of topics"… "Well, his subject is medicine, he has presumably worked in close contact with the nursing profession in hospitals many years." "Yes, that may be so, but what he says still requires careful assessment, for he may be quite sound on medical education and in some fields of medical research, but the problem of the nursing profession is different…It is probably true to say that the problems facing the nursing profession today are more serious and more acute than any in the past 100 years. I cannot help feeling, from what I see and read, that the profession is today facing a very serious crisis, and what happens over the next few years will determine whether nursing as a profession will retain and enhance its prestige or whether, and there is real danger of this, the status of the profession will sink and much will be lost that has been built up by self-sacrifice and devotion since the days of Florence Nightingale (1954, p. 153).

It is remarkable that this Robson gave a presentation about nursing professionalisation at this time, although certainly not remarkable that a doctor was an invited speaker at a nursing forum in 1954. His view on nursing professionalism and still clearly linked to moral/ personal characteristics, and the need for greater (medical) knowledge. He does however go on to promote better nursing education. His concerns are discussed in the following section.

Issues in Australian nursing

After the College of Nursing was founded in New South Wales in 1949 this professional body also accelerated discussions regarding nursing professionalisation in Australia. Professor Robson pointed out the five major issues surrounding nursing at that time (see Diagram 6, page 65). Firstly, there was a growing demand for nurses. The cause of this demand was influenced by the rising population and expanding hospitals. He also mentions, "The growing the complexity of medical and surgical work is steadily increasing the demand for nursing attention per patient". Continuous intravenous infusions and complicated dosage schemes for antibiotics were introduced and nurses were responsible for such medical skills. Secondly, he mentioned a shortage of nurses, although he claims that there is a gap between the metropolitan area and certain districts. Thirdly, Professor Robson stated, "Too many probationers and trained nurses are lost". At this time nurses were required to leave nursing to get married. He wrote, "Marriage must be regarded as part of the normal structure – it is not [a] wastage – it is a healthy sign" (1954, p. 153). It was not their choice to but rather a social norm to have a family. Women were expected to raise families and leave the workforce at this time. Fourthly, Robson noted that the growing complexity of medical knowledge. This theme repeatedly pointed out and Professor Robson mentioned developments in medical technology such as operational procedures, radiation treatments, chemistry etc.

Durdin (1999, pp. 136-8) described the new medical technology and the nurses at Royal Adelaide Hospital in more detail:

> Advances in neurosurgery, in which post-operative care included regular and frequent monitoring of blood pressure, led to nurses acquiring a skill which previously had been the domain of doctors…In the early 1950s thoracic surgery in selected cases of pulmonary TB became possible…In all of the special areas nursing practice was not supported by any theory. Some registered nurses benefited when they were seconded to hospitals interstate to gain practical experience before new units were established at the RAH.

Although some nurses went to other hospitals to gain practical experience, the focus was more on procedures than underpinning theory. During these times when nurses were using the new medical technologies and monitoring skills that used to be the domains of doctors, nurses questioned their role.

Finally, the fifth issue addressed by Professor Robson (1954) was "Educational methods". Robson (1954, p. 153) commented on the nursing education system at that time and stated:

> …I would suggest to you that the present system as it stands today in Australia, and in many other countries, is archaic and inadequate. In my opinion, the systems of training as they stand in Australia are meeting neither the needs of the community for general nursing services, nor the needs of the nurses themselves, particularly those who wish to specialize and occupy places in the advanced fields of nursing, or in teaching or in administration.

He raised further labour issues relating to the nurses' work environment such as working hours, salaries and the diversity of nurses' work. He stated that only 30% to 40% of nurses' work required skills as most of the work could be carried out by non-nurses. The issues raised by Professor Robson at the College of Nursing, Australia in 1954 have been frequently argued since the 1950s. These five issues are not independent but are interrelated.
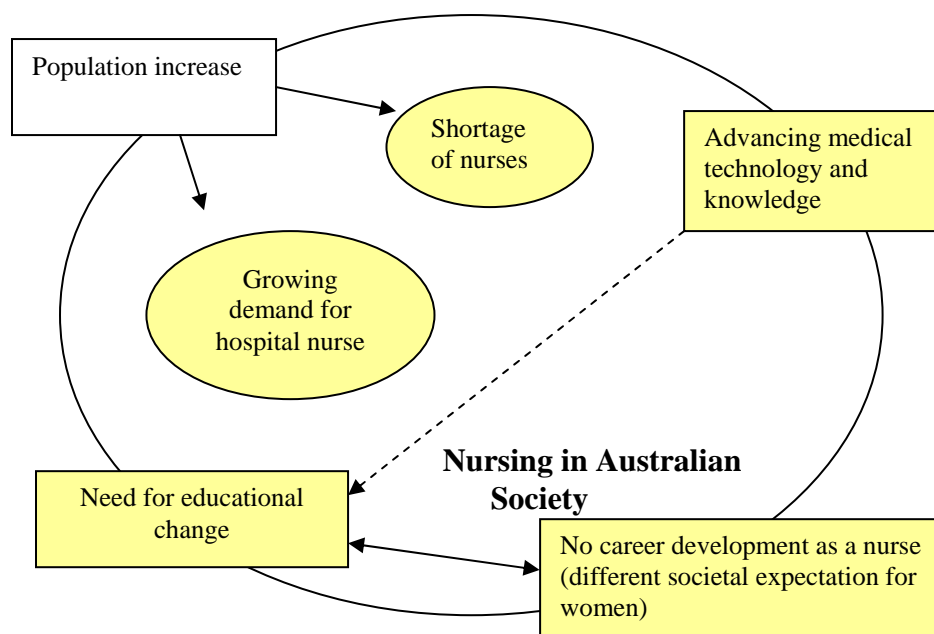
Diagram 6: The issues regarding nursing in Australia in the 1950s (based on Professor Robson's article "The need for a revolution in the nursing profession", *The Australian Nurses' Journal*, July 1954, pp. 152-156)

A new way of discussing and improving the nursing profession at the social level can be observed. However, the issues that Professor Robson addressed still needed to be resolved at the practical level. Since the 1950s, the gap between the ideal situation that nursing had to be recognised as essential and important to society and the reality has been great. These gaps will be demonstrated through a close analysis of the texts in the next section, which considers the next phase after this 1st phase, 'the role of nurses defined by others'.

Phase 2: A nurse as a skilled and good person

The descriptions of nursing during this period can be characterised as "technical and personal". The words used in these descriptions highlight the technical, emphasising the functions of the nurse and the tasks they perform. Furthermore, the description of the nurse's role is based on the character and personality of nurses.

Nurses in the personal sphere – a good nurse as a good person

Texts written in the 1960s showed that influence of the role of the nurses resided in the personal sphere. *Modern practical nursing procedures* (Doherty, Sirl & Ring 1963, p. 1) stated:

> Professional nurses minister to the sick. They assume responsibility for creating a physical, social and spiritual environment which will be conducive to recovery; they stress the prevention of illness and promotion of health by teaching and example. They render health service to the individual, the family and the community and coordinate their services with members of other health professions.

Statements such as this speak of the document role of the nurse is to focus on the sick although the prevention of illness and promotion of health are also mentioned. The function of a nurse is described rather than defined in terms of what nursing is. The description is also definitive by using the terms 'assume' and 'render'. Furthermore, in the section, "Ethics and hospital Etiquette", the First International Code of Nursing Ethics was cited. Following these statements, the textbook states (Doherty, Sirl & Ring 1963, p. 3):

> By the observation of Hospital Etiquette is meant doing the right thing as the hospital does it. It includes the ordinary politeness of life and a quiet and professional manner in the hospital and its precincts. It is a breach of etiquette to talk of hospital and patients in conveyances and public places and discretion should be exercised in private conversation.

This passage was based on the idea of 'Etiquette', regarding how nurses should behave at hospitals and was not based on a code of ethics. Compared to Robson's comment about the nursing profession, this description of nurses is in the personal sphere and education seen as personal development rather than professional.

In these descriptions, the code of ethics and etiquette were mixed together. There is no further discussion of a code of ethics. The reason for this is that nursing in the early 1960s was not by nurses or others to be a profession. The term 'etiquette' is more likely to refer to the comportment of any person in the public sphere. If nursing had been recognised as a profession at the time when the textbook was written, there would be no need to mention etiquette in the context of a code for nursing

professionals. This textbook was originally published in 1944, and still used in most nursing schools for hospital training into the 1960s.

It was not only in the hospital that the nurses were situated at the personal sphere. It was the same in the nursing school. The expectations of nursing students were similar to those who working in hospitals. The texts from the Royal Adelaide Hospital in 1960 show that appraising students focused on the students' characters and not their professional competency. For example, the assessment sheet in 1960 (see Appendix 3) shows how the students were assessed. Attitudes such as courtesy, reliability, loyalty and responsibility were the basis of being a 'good nurse'. The assessment focus is therefore more on the student's personality rather than nursing skills. McKay (1989, p. 151) stated this as follows:

> Underlying many of the actions and beliefs of nurses is their ideal type of nurse: the good nurse. There appears to be broad agreement from those at the top and those just entering nursing on the attributes of the 'good nurse'. Commitment, character and caring are necessary attributes – skill is not mentioned. Because nursing is what women do naturally, then the equating of nursing with skilled work is unnecessary.

Fealy (2004, p. 652) also found that the essentials of a good nurse after 1950 were indicated as 'personal quality to her [sic]'. Although there is assessment for a professional manner, this was imprecise. The assessment sheet in 1963 shows the rating criteria (see Appendix 5). For example, 'attitude' was assessed 'to self', 'to professional authority' and 'to property'. The rating system scored from 1 to 5 was described. The higher quality of the attitude 'to self' was classified as 'immaculate in appearance' and the lower quality of the attitude is described as 'careless in appearance, apathetic'. By raring the scores, the quality of nursing professionality are assessed and the assessor's view of the rating is clearer than previous assessments. Furthermore, it is noticeable that the attitude criteria are specified and there is a criterion to assess attitude to 'professional authority'. The details are not expressed in this sentence, however it can be assumed that the professional authorities in the nursing school and the hospital were the nurse educators (who trained nursing students), ward sisters (who were in charge the ward) and medical officers. Students were expected to obey authority. Thus, the expectation of nursing students at this

time emphasised the personal characteristics involved in being a good nurse. On the other hand, medical technology development influenced the attributes required of nurses. Nurses were urged to gain professional skills by taking over the duties of medical doctors.[39]

Technical and domestic aspects of nurses' work

Medical technology had a dramatic influence on the role of nurses in the 1960s. The variety of care made possible by medical technology accelerated discussions on the role of the nurse. In 1967, a research report was published by Gillam (1967) who had a research grant from the W.K. Kellogg Foundation.[40] It is also noticeable that this research was not a nurse initiative although the emphasis was on education, management and research in nursing at the College of Nursing. Gillam studied the role of trained nurses and the project summarised the role of trained nurses on the wards. He categorised this role as follows (p. 66):

1. Basic nursing
   …Typical nursing activities record [sic] under this heading were bedmaking, personal hygiene, toilet requirements and feeding.
2. Technical nursing
   ...Typical activities were pre-and post-operative care, urinalysis, dressings, administration of drugs, attending to and assisting medical staff, preparation of trays, the taking of blood pressure, the administration of enemata and catherization.

3. Teaching
   "The direct or indirect instruction of trainee nurses and of resident and student medical staff. Indirect instruction included such activity as the close supervision of a trainee's work. In the event, no medical students were present in the wards observed and no teaching of resident medical staff, who were present, was observed".
4. Domestic
   Those activities of a purely "housekeeping" nature such as linen sorting, cleaning, arranging and removal of

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[39] See also *Devices & desires: gender, technology, and American nursing* by Sandelowski (2000). She explains well how nurses seen as professional by using medical devices and machines previously operated by doctors.
[40] Gillam was a researcher in the School of Hospital Administration at the University of New South Wales. The research was funded by the Institute of Matrons of New South Wales and the Australian Capital Territory and the University of New South Wales.

> flowers, dusting, preparation and serving of food, washing-
> up.

5. Miscellaneous
6. Unaccounted
7. Administration

The description by Gillam (1967) focuses on the function of a trained nurse. In his definition of a trained nurse, "she [sic] is fully trained, graduate nurse working in the ward where she has direct patient care responsibilities". He observed nurses' duties in different wards and timed each duty and categorised them. In his categorisation, 'domestic' tasks are included. Gillam research title was, "Automation in nursing". The research was reported by the nursing committee at the National Health and Medical Research Council (NHMRC) of the 67th session, in Canberra in 1968. It commented (Gillam & Cable 1968, p. 12):

> It was noted that Mr. R. Gillam of the University of New South Wales had been investigating the effects of automation on nursing and council approves the following:
> "Mr. R. Gillam be requested to compile a brochure which should be circulated to nurses and hospitals in general. This should give information about automated equipment, as regards the recommended education of staff, their responsibilities and the amount of experience thought necessary to enable them to become competent in the use of such equipment".

Indeed, the task categorisation by Gillam (1967) shows that technical nursing occupies about more than 10% and up to 60% of all nursing tasks, followed by administrative tasks. He emphasised implicitly how much of nursing at that time involved technical nursing due to technological developments. Thus, the role of a nurse in the 1960s started to be recognised as a 'technical nurse'. It is interesting to note the contrast between 'technical nurse' and 'domestic nurse'. In the early 1960s textbook *Modern practical nursing procedures*, hospital housekeeping is explained. Doherty et al. wrote as follows regarding to the purpose of this duty (1963, p. 13):

> It is to the advantage of the student nurse to have a working knowledge of domestic affairs, for when qualified, she may have to supervise the work of maids and assess the amount of time required for its satisfactory performance. However, the fact that dust may be heavily contaminated with pathogenic bacteria should preclude her from cleaning duties or limit the time devoted to such work to a very brief pre-clinical period, before she undertakes any nursing duties with patients.

The first half of the passage is based on the belief that importance of having experience of domestic affairs, because it would be useful when she [sic] supervises maids and the experience enables her to give a good instruction. The latter half of the passage is not based on 'importance of experience' but on clinically based reasons in terms of hygiene and infection control. Gillam (1968) also showed that the nurses' role in the 1960s included domestic work such as cleaning beds, lockers, pans and other equipment.

In summary, in the technical and personal nursing definition used in the 1960s, the role of a nurse focused on 'what nurses should be like' and the stage of defining of the nurses' work. The nurses' role was classified and thus became part of the professionalisation process. Furthermore, certain authors (Gillam 1967; Gillam & Cable 1968) wrote that the nurses' role is categorised by the function and the duties of nurses. However, the nurses' attitude towards patients and the nursing profession were not mentioned during this decade.

Henderson exception

By the end of the 1960s, Henderson (1969) published *Basic principles of nursing care*, the revised edition of the original book published in 1955. In the first edition of the book, Henderson questions the definition of nursing and the function of nurse and wrote (Henderson & Nite 1955, p. 4):

> In any age, under any provision for medical care, each type of worker on the medical team should be recognized as having a peculiar or unique function, no matter how many functions he has in common with others. Certainly the members of each vocational group should be more competent in performing some activities than are the workers in any other vocation. This brings us to the question: What is nursing that is not also medicine, physical therapy, social work, etc?; and what is the unique function of the nurse?

In 1955, she was years ahead of Doherty et al.'s (1963) definition by focusing on the unique function of nurses. Henderson had tertiary qualifications and she gives the following definition of nursing:

> Nursing is primarily assisting 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. It is likewise the unique contribution of nursing to help the individual to be independent of such assistance as soon as possible (p. 4).

Henderson analysed a number of definitions of nursing before she wrote her own. She criticised various definitions as not being specific to nursing. The national (U.S.) committee's pressure toward defining nursing was influential in this. Henderson and Nite (1955) wrote, "A national committee made up of nurses from many parts of the United States worked intensively for two weeks in 1947 to produce a statement on "the probable nature of nursing". The committee's report, *Nursing for the Future*, by Esther Lucile Brown was also called the 'Brown Report'. The Brown Report used definition of nursing to influence a more nation-wide understanding of the term.

Between the 1950s and 1960s, the role of nurse was defined in the functional sphere as an individual who did her work. The individual context of a nurses' work was that in order to be a 'good nurse', one's personal characteristics had to be in line with organisational expectations. Henderson's definition was a bridge for nurses becoming members of a healthcare team, but this was not fully realised until the 1990s. The texts such as the assessment sheets and nursing textbooks indicate the nurses' characteristics based on their calling for profession and good moral behaviour. Nursing training was used to make these characteristics (Rafferty 1996) and by doing this it represents legitimatisation of nurses. In this sense, nurses were in the personal sphere, which also shows what characteristics including the personal characteristics should be. Diagram 7 below shows a nurse in the individual sphere. Mirroring the discourses in sociological discourses in Chapter 2, the development of the nurse in the functional and organisational sphere will be analysed in the next section.
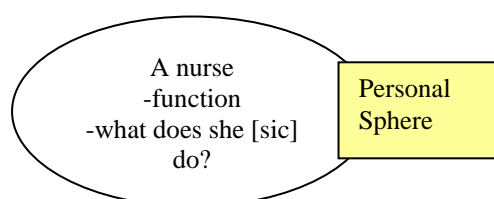
Diagram 7: The role of nurse in the 1960s

Phase 3: A nurse as a member of the health care system

The 1970s was a decade in which nurses were accepted as organizational members. Nurses moved from the personal to the public sphere. In this phase nurses are defined as 'organisational members'. A nurse recognised as 'organisational members' was not only discussed in hospitals, but also the subject of discussions and debates in the nursing education system.

The public sphere of the role of nurse

Discourse of the nurse role in Australia was raised and it was the subject of Ruth White in 1972 for research on behalf of the National Health and Medical Research Council. White graduated from Columbia University Teachers' College with a doctorate in education, and worked at the University of New South Wales as a researcher in nurse education. She researched a plan for nursing education in New South Wales. The report published by White was based on her doctoral study. In the report she (White 1972, p. 9) stated:

> The present role of the registered nurse, in direct personal care is enacted almost entirely within the hospital. The proportion of nursing time available for fulfilment of the role varies according to the organisation of the institution. It is not an exaggeration to state that in general hospitals (excluding specialist wards) at least half to three-quarters of nursing time is not spent on direct care function. Meanwhile, in a situation where there appears to be little impediment to the full use of professional nursing knowledge and skills, together with community health needed waiting to be met, the role of the nurse has not been extended or expanded.

Nursing in the 1970s focused on the institutional, especially acute hospitalised nursing. Keleher (2000, p. 260) who studied the history of public health nursing argues that the hospital based nursing training system motivated nurses to focus on an illness centred model during the 1970s. The hospital setting for training nurses became a key issue in the 1970s. Nursing as taught in hospital institutions was limited when the concept of nursing had expanded to included community-oriented health care. Community oriented care had been an important factor in a paradigm shift, i.e. seeing the person with the illness rather than seeing the illness centred

patient. This paradigm shift also influenced future reports. Based on White's report, the role of the nurse was described at the 76th session of the NHMRC in 1974 as follows (NHMRC 1974, pp. 36-8):

> For the individual patient, doctor and nurse together provide care for the whole person within particular areas and levels of expertise. In addition to providing basic physical care, the nurse is healer, adviser, comforter, and technician. Of these, the functions of healer or treater have been predominant.

The term 'patient' was used in this definition and nurses would care for the whole person. The nurse is not only the person providing the care but also the doctor provides care. The existence of doctors in the nursing care context created a new paradigm for the role of nurse. Emphasis was placed on team work in the care of the patients and in the 1970s, the role of nurse was defined in the context of organisational relationships such as that between patients and doctors. Thus the role of nurses changed from the individual sphere to the organisational sphere.
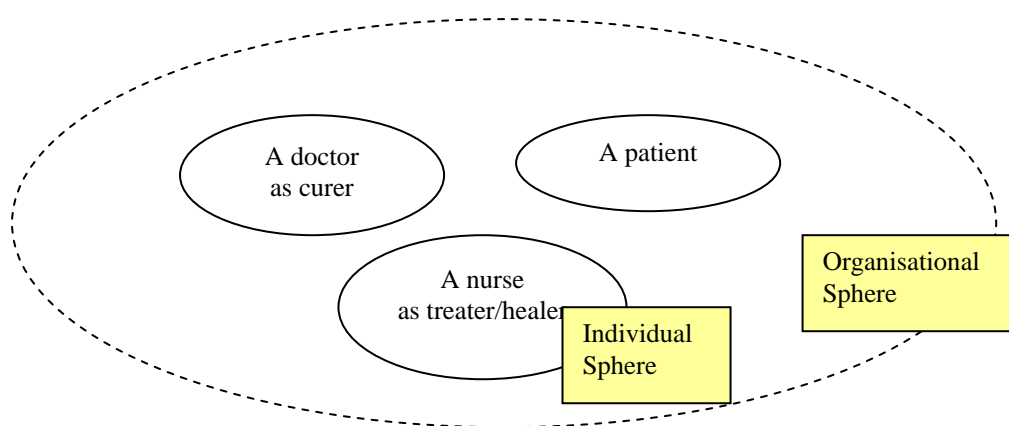
Diagram 8: The role of nurse in the 1970s based on White (1972)

The organisational role of nurse is seen in government reports as well, such as the Sax Report in 1978 which canvassed nursing education. This is the only federal government report but there were state government reports such as Truskett Report in 1969 and Ramsey Report in 1971. Russell (1990, p. 117) described the plethora of reports as follows, "The establishment of 15 expert committees during the 1960s and

1970s demonstrated the very real concern of state governments and nursing organisations about the nursing profession and nursing education".

In this movement, the nurse's role and education for the role became the focus of discussion and debates were plentiful. Having education appropriate for discipline based knowledge was also a major development. It had been named as one of the measures the professional in the structural functionalist approach to understanding professions – "a professional has a theoretical body of knowledge leading to defined skills, abilities, and norms" (Leddy & Pepper 1989, p. 5).

Transition into the tertiary sector

The public aspect of the role of the nurse pushed for nursing preparation from training to education. After the report of the 76th session of the NHMRC in 1974, *Goals in Nursing Education* was published in 1976 (Royal Australian Nursing Federation et al. 1976). The report was developed by a working party consisting of RANF, College of Nursing Australia and the National Florence Nightingale Committee. The report explains (p. 1):

> This document was intended to provide a basis for the formulation of policy…The nursing profession expressed considerable concern that actions and decisions integrally related to professional development seemingly were undertaken without the knowledge or appropriate involvement of the profession itself.

In the report, the goal for nursing education - transition to the tertiary sector - was determined from interviews with nurse educators in Australia. Changing the place to teach nursing from hospitals to schools implied a shift to a discipline of nursing from a skills based training. The shift also meant changes in how nursing might be governed.[41] Nurse education in the tertiary sector provided recognition of nursing as a discipline but also led to debate about who governed nurses' education.

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[41] This shift is further discussed in Chapter 5.

The case of South Australia

The first step in tertiary education begun with implementation of the Diploma of Nursing at the Sturt College of Advanced Education in 1975 but discussions regarding tertiary education for all nurses continued. The process involved other nursing professional organisations and nurses and nurse educators assisted their power and authority to push for reform. A report to the Committee of Enquiry into post-secondary education in South Australia was submitted by the College of Nursing, Australia, S.A. State Committee and the S.A. Branch of the Royal Australian Nursing Federation in 1976 (The College of Australia, S.A. State Committee & Royal Australian Nursing Federation 1976). The purpose of the report was to document problems regarding nurse training and made recommendations about nurses education at the tertiary level.

The report highlighted five problems which were: the cost benefit between nursing training and tertiary education; the disruption of learning due to the training system; the labour aspect of nursing training; time required for nursing training (i.e. shorter duration) and "difficulty in developing interdisciplinary studies". Although this task force's report was 'widely circulated amongst nurses and politicians throughout the country' and appealed for the introduction of tertiary education for nursing education, there were also reports that came to opposite conclusions. Nicholson (1998, p. 124) explained:

> For example, a South Australian report highlighted the financial burdens associated with training nurses and it argued that the cost of education nurses students at a CAE was more than four times the cost of training one in a hospital based school of nursing.[42,43] The authors therefore concluded that the cost of transferring nursing training into the tertiary education sector was prohibitive. The Australian Medical Association (AMA) also agreed that basic nurse training programs should remain within the hospital schools. They argued that there was no need to change the educational venue as the schools of nursing had a longstanding record of producing practical RNs with good basic skills.[44]

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[42] Based on Bennett C. et al., 'The cost of training registered nurses in Australia', Working Paper No 25, National Institute of Labour Studies, Flinders University of South Australia, p. 57.

[43] See also Appendix 11: An analysis of costs for training nurses.

[44] Based on Bulton J., Blewitt, N. 'A New Deal for Nurses' Needs' in *Education Series*, Canberra 1981, p. 11.

The main argument against tertiary education of nurses was economic and the AMA's belief that hospital-trained nurses were more 'practical'; professional knowledge was not necessary, if nurses were to continue to fulfil their traditional role as doctors' handmaidens (was already in place in 1975 but not for all till 1993 by Commonwealth government decision). Durdin (1991, p. 194) described the acceptance of one of the first tertiary programs in Australia:

> Informal discussions with nurses revealed support from the profession. With the agreement of the South Australian Ministers for Health and Education, Dr Speedy sought approval and funding from the Board of Advanced Education and the Australian Commission on Advanced Education for a basic nursing course. He received news of the Board's approval for a course at the end of March 1974, just as a weekend conference to discuss a possible curriculum with members of the nursing profession was about to begin.

At the college, nursing students were full-time students. The different administrative and funding systems between the hospitals and the Education Department were the key to a shift in control of nursing education. The tension between students as learners and as workers was resolved when nursing students were tertiary students. Moreover, the issue about who could recognise and assess nurses as suitable for registration was resolved when the College of Advanced Education became responsible for the assessment of nursing students to be registered nurses. The authority for assessing of students was explained by Durdin (1991, p. 195):

> The Nurses Board's support for the tertiary programme was also apparent in its appreciation that a different curriculum required a different form of assessment. From the outset the Board accepted the College's assessment of its students as a basis for registration rather than require[ing] them to sit for the Nurses Board Examination.

The RAH nursing school and nursing course at Sturt College of Advance Education developed different emphases. The largest pre-registration course in Australia was conducted at Sturt College of Advanced Education (1978). The ideology of nursing was reflected in nursing education at the College. The course proposal in 1976 stated (Sturt College of Advanced Education 1976, p. 3):

> For example, students from early on in their education may be involved in the total care of patients carefully selected so that their needs are able to be met by the students at that level of experience, rather than meeting only certain needs for a large number of patients and thus becoming task – rather than person – focused. It is believed that this will be an effective preparation for the team role that nurses will occupy at Flinders Medical Centre and in other health services.

This explanation describes the role of the student being supported to give holistic care, then of the nurse as a member of the health care team and as providing patient-centred care. These descriptions of nursing show how and what kinds of attributes nursing students should learn during their study. The nursing students' expectations and attributes will be further discussed in Chapters 6 and 7 with reference to the historical curricula. The nursing education system enabled the role of nurses to become more socially oriented than before as will be shown on the following pages.

Beginning of controlling nursing registration – power in assessing competency

In this changing nursing education environment, the role (the degree of authority) of the Nurses Board changed. It assessed nursing students' standards and maintained nursing registration. The commencement of nursing education at the tertiary level meant that the Nurses Board handed over the role of assessment to tertiary institutions, as discussed previous pages. This shift of power in assessing nursing competency from the Nurses Board to the tertiary system, meant that nurses had a new sense of autonomy and professionalism in the tertiary education context. This divergence in roles of the College and the Nurses Board saw nursing professionalisation enter a new phase.

Phase 4: A nurse as an unique occupation in globalised society

In the 1980s nurses became recognised not only as members of health organisations, but also as having an important role in the health of the wider community (Dingwall, Rafferty & Charles 1988). From social movements such as consumer's rights and students' rights, clients expected to receive better service and to have a more egalitarian relationship with health care providers. In this context, nursing expanded into the community and nurses had more opportunities to contact a variety of clients.

Moreover, a new wave of immigrants entered Australia. The National Health Medical Research Council (NHMRC) report in 1983 clarified the public role of nursing. In the report, the role of nurse in Australia was explained as follows (NHMRC 1983, p. 2):

> The role of the nurse in Australia varies according to the geographic location and the population with whom the nurse works, the particular type of hospital or health unit in which the nurse works, the stated aims of the employing authority, and the expressed health needs of the community. Wherever the nurse is working, however, he or she is responsible for assessing the nursing needs of the patient, client, family or community, and identifying the resources required to meet those needs. The nurse works with the patient/client to plan the nursing care required, undertake what has been planned, document what has been done, and evaluate the results of the care that has been given.

In the first half of the description is the place where nursing would be provided. The place had expanded from medical institutions to the community. The latter part of the description outlines the duty of nurses. The last sentence explains how nurses would provide nursing care. This description of nursing care implies a nursing process but there the term 'nursing process' was not used. The appearance of nursing process indicates development of nursing knowledge and the discipline of nursing.

In the 1980s, nursing professionalisation accelerated due to influences both internal and external to nursing. The place where nursing occurs was stated for the first time at the national level, although such a statement had been made about district nursing in the late 19th century.[45] The emphasis of nursing expanded from the organisational sphere to the societal sphere. Another factor professionalising the role of nurse was the introduction of the idea of competencies. The definition of registered nurse in the Australasian Nurse Registering Authorities Conference (ANRAC) stated (Australasian Nurse Registering Authorities Conference 1990, p. 65):

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[45] The District Trained Nursing Society started in 1894. Durdin describes society them as providing "another avenue for the services of trained nurses. Many people living in the poorer districts were confined to their homes by chronic illness. The Destitute Board provided a visiting medical service throughout the colony, but there were limits to what a doctor could do to relieve some aspects of suffering. Until the advent of trained nurses there was no possibility of providing an appropriate domiciliary nursing service" (Durdin 1991, pp. 29-30).

> The Registered Nurse is the first level nurse who is licensed to practice nursing in the fields in which he/she is registered without supervision, and who assumes accountability and responsibility for his/her own actions. The nurse is also referred to as the professional nurse. The role of Registered Nurses includes the following integrated components: clinician; care coordinator; counsellor; health teacher; client advocate; change agent; clinical teacher/supervisor. The role of the Registered Nurse includes the responsibility to examine nursing practice critically and to incorporate the results of personal action research or the research findings of others. It is the Registered Nurse's responsibility to understand the role and function of enrolled nurse and to ensure that they are placed in situations where they are required to function only within the limits of their education and competence. The registered Nurse determines, on the basis of client needs, whether nursing will be given by Registered Nurse, whether nursing will be given by a registered nurse or an enrolled nurse.

In this confident statement of responsibilities and accountability nursing has completed the professionalisation process that begun in the 1950s. The statement implies that the role of nurses was not only recognised in society, but also that a nurse had the professional responsibility to reflect on his/her own practice. The role of nurse expanded from the delivery of care to include working in a team to produce definite outcomes from nursing activities. Nursing became a continuous process and nurses took responsibility for their patients (clients).

The nursing function became more professional. However, the description of clients (such as how the nurses see the clients and the relationship between a nurse and a client/patient) disappears. In other words, the discussion about the individual level sphere shifted to the social sphere. In the 1990s, there were further reports on the role of the nurse. The following section will describe the role statements in the 1990s and the changes from the 1980s to the 1990s.

The nurse role statement in the 1990s

In 1991, the National Health and Medical Research Council (NHMRC) published *The role of the nurse in Australia.* The changing nature of the role of nurses in Australia was influenced by the changing role of women in society, technological developments, growing budgetary constraints, increase in consumer awareness, changing direction of health care toward promotion and self-help, etc. (NHMRC

1991, p.1). The eight roles described by the Benner and Fenton report (cited by NHMRS 1991, p. 4) were:

- The clinical, caring role
- The teaching counselling role
- The managerial/co-ordinating role
- The patient/client advocate role
- The professional developmental role
- The nurse consultant role
- The nurse educator/academic role
- The nurse researcher role

Compared to the ANRAC role statement in 1988, the role of professional development, nurse educator/academic and nurse researcher is more clearly stated in the 1991 statement. In the 1988 statement about the role of nurse, professional development role is described as 'change agent' and nurse educator/academic and nurse researcher as 'clinical teacher/supervisor'. What does this mean in changes regarding the description of the nurses' role? The term 'agent' implies that someone (i.e. the nurse) works to affect changes and there is an intention to do something for a specific purpose. However, the term 'change agent' does not specifically describe the role of a nurse: "The role of the registered nurse includes the responsibility to examine nursing practice critically and to incorporate the results of personal action research or the research findings of others". In this sentence, the research role is not clearly stated and the role of 'academic' is not discussed.

The 1991 statement describes nurses as responsible for examining their practice in order to improve practice whereas this role was not described in the 1970s role statements, and is a clear expression of professional practice. In the following sections, I will discus the elements influencing nursing since the 1980s and analyse the texts describing these issues. The central and most controversial concept during this period was that of 'competency'. Diagram 9 in next page shows the factors influencing this concept (Gonczi, Hager & Oliver 1990, pp. 7-8). The competency movement was driven by the need to assess the qualifications of immigrants to Australia and the related issue of a new shortage of workers. In Australia, both the transition of nursing into tertiary education and society's demand for the transferability of nursing promoted the use of 'competency' in nursing.
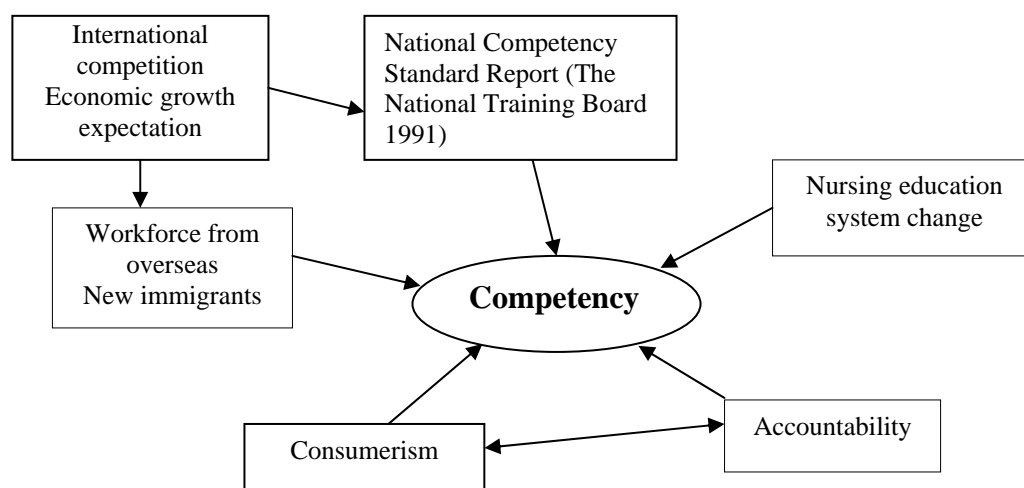
Diagram 9: The influences on the competency movement during the 1980s

Changing Australian society – new immigration policy and its influence

After the Second World War, the need for a workforce was urgent and immigrants from overseas, especially from European countries, were welcomed. The number of immigrants from Europe in the 1960s had decreased due to reconstruction in the Europe (Sekine 1988). As a result, the Australian government started to accommodate people from the Middle East and Asia. The diversity of countries where people are from expanded and the government's attitude towards accommodating immigrants also changed. The policy of assimilating migrants into Australian society changed to that of multiculturalism implemented in 1973 under the Whitlam Labour government (Sekine 1988, p. 288). In addition, the Racial Discrimination Act 1975 was legislated. Multiculturalism influenced nursing in Australia. These changes continued into the 1980s (NHMRC 1983):

> …the nurse shares with other citizens the responsibility for initiating and supporting whatever action is necessary to meet the health and social needed of the community. Because the population structure of Australia has changed to a multi-cultural society, the nurse should take more account of the different health perspectives of people from diverse ethic backgrounds, and recognise that health is a constantly changing state of physiological, psychological, social and spiritual well being arising out of the interaction of people with their environment (p. 85).

The description of nursing here is based on the health need of society and in particular the various ethnic backgrounds. Nurses are also seen as taking responsible action to meet these various health needs. In this sense, the nurse is considered as an essential agent for health maintenance in society. The social changes in terms of new immigration into Australia brought about a need to measure quality in the nursing and other industries. In other words, the new policy for immigration required a standard to assess immigrants' work suitability and ability. This is one of the factors influencing the competency discussions in the early 1990s.

Competency setting – improving the nursing quality and who provides care[46]

The Australian Nurse Registering Authorities Conference (ANRAC) was held in 1986. At the conference, the goal was to develop national minimum competencies. The report outlined two major reasons for this drive to national competency standards.

Competency-based education in other countries influenced the movement in Australia. ANRAC states (Australasian Nurse Registering Authorities Conference 1990, p. 1), "The situation in Australia appears to mirror the experience of the U.S.A. and U.K. The health care professions (and specifically nurses) are leading the application of the competency based model of professional education". The other is from the Federal Government implementing a competency-based model of skills recognition for immigrants looking for professional accreditation. The latter reason proved more influential in accelerating the adoption of a competency model in Australia. Immigrants seeking professional accreditation had increased dramatically due to the immigration policy, which confirmed that people having skills, such as health professionals, education professionals, etc. were eligible. There was an increasing need to assess the competency of immigrants looking for work in Australia (Masters & McCurry 1990). Working as a nurse was one opportunity for immigration to Australia so competency discussions referred to the assessment of a nurse's ability. Naturally, there was a need to assess overseas nurses as matching the

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[46] Competency influence to curriculum will also be discussed in Chapter 7.

level of Australian registration (NOOSR 1995, p. vi). The context of the arguments shifted from recognition of nurses in society to their recognition internationally (Gonczi, Hager & Oliver 1990). Nursing was the first professional group to develop competency standards. This needs to be read as part of nursing's strategy to gain professional recognition by implementing this concept.

Focus on the quality of nursing practice

The competency debate in the 1990s shows how nurses as a professional group defined themselves. In an environment of labour force shortfall, Gonczi et al. who were researchers who were involved in the competency project (1990, p. 7) stated that the usefulness of competency-based standards was central in the 'maintenance of professional standards'. They also wrote, "Competence is focused on *performance* of a *role* or set of *tasks*" (1990, p.9). Here determined to be a knowledge-based profession seen as nurses are again being assessed in terms of 'tasks'. The Gonzi et al. statement is at odds with purpose of standards cited below in the first edition of *Standards for nursing practice* (Royal Australian Nursing Federation National Professional Development Committee 1983, p. 1):

> A statement of a profession's standards incorporates the values held by members and indicates for society what can be expected from members of the profession. Hence, a profession's standards from the basis from which practice may be judged both by the profession and by society. Willingness for the practice of the profession as a group, and its members as individuals, to be judged by peers and by society is a demonstration of professional accountability. One of the hallmarks of a profession is its social mandate to provide high quality service to citizens.

Here, it is assumed that a profession. Moreover, it is clear that interaction of nurses with peers and with society is a requirement of professional standing.[47] In this sense, the social and individual definition of nursing as a profession recognises the importance of the quality of nursing.[48] Diagram 10 in next page shows the interrelationship between nurse patient, doctor and society in the 1980s. Nurses had

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[47] The concept of 'collegiality' is discussed in Chapter 2.
[48] The concept of 'individuality' and 'group' will be discussed in Chapter 4. The contradiction between these concepts will be further discussed as nursing knowledge increases in complexity.

changed from being defined in terms of individual characteristics to being recognised in terms of socially sanctioned standards and holds of nursing knowledge.
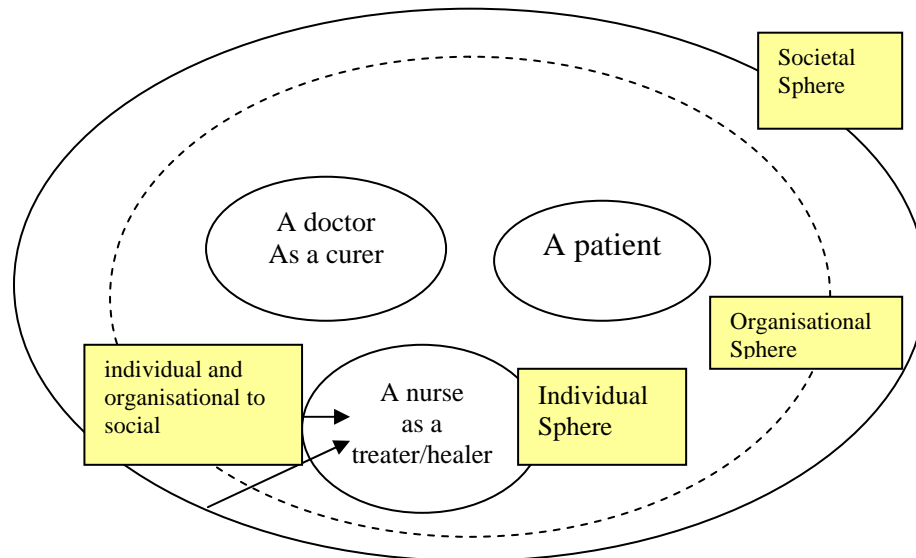
Diagram 10: The role of the nurse in the 1980s

The tensions over control of competency in the nursing profession

Competency in Australia begun as industries reorganised to assess incoming immigrants, as explained previously. *National Competency Standards: Policy and Guidelines* (The National Training Board 1991, p. 5) stated:

> In Australia the linking of industry restructuring, to meet challenges of international competition, with occupational classification restructuring through the industrial relations system has been the principle driving force for change…Competency is the product of training and experience. Curriculum development and accreditation are complex and lengthy processes. Introduction of substantial change in curriculum in turn requires the acquisition of different competencies by trainers…to be able to deliver satisfactory accredited training that is both nationally consistent and economical.

The emphasis of competency by The National Training Board is on improving and standardising training courses in Australia. The concept of competency in education was also emphasised. In the report *Establishing competency-based standards in the professions*, a competent professional is described as (Masters & McCurry 1990, p. 4):

> …a person who has the attributes necessary for job performance to the appropriate standard. This definition focuses on three elements: attributes, performance and standards. Attributes such as knowledge, skills and attitudes, in combination, underlie competence…

The arguments about nursing competency in nursing education were about the level of graduate assessment and nursing competency standards. The federal government's competency focus was on vocational training for nursing. The *Campus Review* in June 1993, reported on arguments in that publication for April 29 - May 5. Dwyer, Registrar, at the NSW Nurses Registration Board wrote (Dwyer 1993):

> The NSW Nurse Registration Board wishes to correct any misunderstanding which may result from statements contained within the article "Health dean attacks nursing competencies' as restrictive"…concerning the development and use of the ANRAC competencies…Prior to the development of competencies courses leading to registration followed strict syllabuses and students were required to be successful in summative formal external registration examinations in order to be eligible for entry to the register. The ANRAC competencies were adopted after wide consultation with representatives of the profession, including representatives from the higher education sector, through workshops and committees.

Dwyer explains that the introduction of competencies into nursing education was not to control nursing registration, but as "a guide for curricula development, whilst enabling institutions to continue to develop programs which are dynamic, progressive and in accord with the particular educational philosophy of individual institutions". Russell, as Professor at the Nursing Faculty, University of Sydney wrote in the *Campus Review* (June 3-9, 1993) on the difference between the federal government's competency agenda and nursing competencies as the cause of confusion (1993, p. 11):

> Unlike the government's agenda, the nursing competencies have been developed, with wide consultation, by the profession itself…They are a set of minimum outcomes which nursing graduates should have before they are registered – and they are not terribly prescriptive in terms of setting curricula…It's a little unfortunate that the government's plans have left some people confused about the whole issue of competencies in nursing.

The transition of all nursing education to the tertiary education system and the introduction of competency standards produced much discussion and confusion at the same time. Although as Russell claimed nursing competencies were developed after wide consultation, many nursing professionals feared both a loss of their hard won control over nurse education and a return to a task orientation, with the introduction of ANRAC competencies.

Competency control and the professions

The competency debate involved both the nurses' workplaces and the education institutions where they learnt their profession.[49] In 1993, "National competencies for the registered and enrolled nurse in recommended domains" was published. Following their publication, a 2005 report describes the purpose of competency more clearly, as follows (ANMC 2005, p. 1):

> The registered nurse demonstrates competence in the provision of nursing care as specified by the registering authority's licence to practice, educational preparation, relevant legislation, standards and codes, and context of care…The registered nurse provides evidence-based nursing care to people of all ages and cultural groups, including individuals, families and communities.

The quality of nursing is now claimed to be ensured by the use of evidence for practice. As I described in Chapter 1 evidence-based practice has become the most recent powerful means for managing uncertainty, in everyday practice and follows reflective practice and 'personal action research' of the 1990s.

The domains of the national competency standard changed from 'professional/ethical practice', 'reflection', 'problem solving' and 'enabling' in 1998 to 'professional practice', 'critical thinking and analysis', 'provision and coordination of care' and 'collaborative and therapeutic practice' in 2006.[50, 51] Observing the texts written in 2006, the idea of ethical practice is considered in the context of professional practice. Although the term relating to the professional self does not appear in the domain

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[49] More discussion will be shown in Chapter 7.
[50] See Appendix 8.
[51] See Appendix 9.

'critical thinking and analysis', the 2006 domain is similar to the 1998 text. In the 1998 text, the term 'research' was used whereas in 2006 the more recent term 'evidence-based' is used.

Chapter summary

I analysed the role of nurse statements as text data in this chapter. The role statement is an agenda of nursing professionalisation. Using the perspective of 'who', concerns about the role of nurse and 'how', indicated the shift of nurses' role from the individual sphere to the organisational and finally the societal sphere.

The descriptions of the nurse's role in the 1950s were dominated by views of medical doctors who defined the role. However, the international movement legislating for the regulation of nursing became an important step towards professional status. The function of the registration board was to regulate the nurse workforce with members of the Hospital Association, consisting mainly of administrators. The connection between hospitals and nursing training schools was strong, and nurses had insufficient power to demand changes in the training system. It took another twenty years for tertiary education in South Australia and forty years for university education to accept nursing programs.

I found that the role of nurses shifted with social movements and technological developments. Technology influenced the character of nursing. In the 1980s, the movement for competency in nursing created opportunities for nurses to discuss nursing professionalism and as a discipline in education. Debates occurred in nursing education during this period of transition to tertiary education. In the next chapter, the development of 'thinking tools' by nurses is investigated.

CHAPTER 4

THINKING TOOLS FOR NURSING

Introduction

The internal uncertainties surrounding nursing's professional development were described in Chapter 3, where I traced the historical descriptions of nursing. Descriptions of the nursing profession in the texts reflected the formations of the profession. The reduction of external uncertainties in the nursing profession led to the situation where nurses were empowered to clarify any remaining uncertainties in their profession themselves. The internal power of the nursing profession is now obvious in its autonomous regulation and control over nurses' practice. This change can be described as the nursing profession's growth in autonomy and self-governmentality. This power is described as an increasing ability to describe the nursing discipline and reduce uncertainties about its discipline (see Chapter 2 and 3). In this sense, power internal to nursing is used to develop nursing knowledge and to sustain its professional standing.

In this chapter, development of the nursing profession is described in terms of its control over knowledge development from within, and will be explored through an analysis of how nursing process discourses operated to accomplish this control. Why do I focus on the term, 'nursing process'? It is my contention that problem-solving discourses such as those underpinning the nursing process acted as a trigger to guide nursing knowledge development. Parfitt (2005, p. ix) claims: "The introduction of this scientific thinking into nursing has changed the way that nurses think and work". Discovering the discursive operations of the concept, 'nursing process' reveals nursing knowledge development occurring through interactions and debate over what counts as the 'nursing process'. In using the expression 'tool' I show how this is used to systematise nursing and provide a different perspective on nursing, both theoretically and practically. In this chapter I will demonstrate what ownership of this tool has brought to nursing.

The nursing process context

Why did the term 'nursing process' gain ascendancy in the 1960s? As we have seen earlier, society had changed radically since the end of the Second World War. Nursing not only had issues such as a shortage of workers, desire for professional development and better working conditions, but nurses were also eager to achieve professional status and to play a role in better-managed hospitals. The most significant social movements from the 1950s to the 1960s when the nursing process was discussed were: significant industrial development and scientific development and life-style changes based on these developments. As Dolan et al. (1983, p. 240) described it:

> The twentieth century has also witnessed a phenomenal improvement in the general standard of living, the lengthening of the span of life, the identification of the causes of many diseases…. In the latter part of the century, social movements, such as the civil rights, student, consumer and women's movements, had a profound influence on the direction of health care….This century has encompassed the transition from candle-light to satellite, from the horse and buggy era to the space age.

As Dolan and his co-writers explain, scientific developments had seen advances in biology, bacteriology, pathology and so on. For instance, electrocardiography was developed by Willem Einthoven in 1901, insulin was recognised by Drs. Banting in 1921 and this discovery made the foundation of endocrinology possible. New vaccination discoveries and medical innovations, in the 1960s and the 1970s, such as open heart surgery, human organ transplants, replacements of joints and in vitro fertilization were important. Countless medical technologies had been invented in the twentieth century. Nursing was influenced by this development. Medical developments influenced the role of nurse as techniques such as giving injections, doing physical examinations and observing vital signs, which required nurses to be more responsible than ever before and to have these techniques underpinned by possession of medical knowledge. The changes in the nurses' role were described in Chapter 3 and in this phase of nursing as was medicalised and used knowledge based on medicine.[52]

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[52] There will be more detailed discussions about medical knowledge-centred nursing in Chapter 6.

The automation of machines such as washing machines, refrigerators, and dish-washers made people's life physically easier. Clearly though, such developments created the need for an educated workforce, and there was a call for the tertiary education sector to have more students. Medical technological developments became part of the new treatments to cure patients' diseases. Dolan et al. (1983, p. 360) describe the remarkable scientific advances as diversifying the hospital staff and its skill set:

> …gradually, general hospital wards were modified into specialized care units, which focused on the degree of illness of the patients rather than solely on the nature of their medical problems. Simultaneously, many hospitals began to concentrate on acute episodic illness that responded to short-tem, high-technology treatment. Once clinical stability was achieved, patients were usually discharged from the hospital to recuperate…hospital generally had a greater percentage of very sick patients than they had in the past, and the intensity of hospital nursing escalated accordingly.

This happened in the 1980s in the U.S. in order to improve managed care and in Australia during the 1990s. Higher and more complex clinical skills associated with development of high-technology treatment were required in acute care settings. Due to the more complicated nature of nursing skills and responsibilities, nurses who were in the educational positions and leaders in clinical areas realised the importance of its meaning and questioned their role. For example, the role of nurses in 1991 described this (NHMRC 1991, p. 11), "Nurses will need to develop additional skills to manage the technological change, and to ensure that technology is appropriate". With the assumption that nurses would be technologically skilled, the text also described this role expansion, "It is anticipated that the cost of health care will continue to rise, due in part to the increased use of technology" (NHMRC 1991, p. 11). Although there is no explanation of the nurses' attitude toward this trend, this text showed that the relationship between technology development and nursing in terms of the role and the context of nursing changes.

In this technologised atmosphere, the quality of life improved dramatically, but on the other hand, ignored or isolated people started to raise their voices, leading to the development of social movements demanding things such as human rights, women's

rights, students' rights and consumers' rights.[53] Andrist (2005) wrote about the influence of the 'second wave' of the women's movement in the U.S. as follows:

> …began in the early 1960s with the report of President John F. Kennedy's Commission on the Status of women (1963), and the publication of the Feminine Mystique (1963) by Betty Friedan. But it was not until the early 1970s…Nurses became radicalized to their subordinate roles, the call for professional unity was heard, and several nurse scholars began a critical analysis of the historical impediments to nursing. Wilma Scott Heide, then President of the National Organization of Women (NOW), voiced a clear connection between nurses' issues and women's issues needed to play the doctor – nurse game in order to survive…

These social movements indicated the elements influencing nursing professional development in the U.S. and their spread worldwide. They are an essential backgrounding to understand how nursing has been formed through these movements. In Australia, nursing theory was not used until the early 1970s (Condon 2000, pp. 108-9).

As I discussed in Chapter 3, during the late 1950s to the 1970s the definition of nursing profession and its role was debated intensely. The discussions over 'nursing process' and 'the definition of nursing and the role of nurse' were parallel at that time. Behind these arguments, nurses wanted to be recognised as professionals in society rather than as 'handmaidens' of doctors with little or no autonomy. For the recognition of nursing as a profession, a set of theoretical body of knowledge was required to demonstrate "the defined skills, abilities, and norms" (Potter & Perry 1985). As I discussed in Chapter 2, nursing first followed medical knowledge while taking over some of doctors' tasks to raise their professionals' status. While the nurse's role was expanded into the organisation as a health care team member, the thinking tool of nursing was utilised in the organisation as well (detail will be discussed in this chapter). The changes of the tool's purpose shows how nursing was influenced by technology over time. The nursing process and its discourses will reveal its unique role in accelerating not only nursing knowledge development, but also developments in nursing practice (Uys & Habermann 2005, pp. 4-5).[54] Nursing

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[53] See discussion in Chapter 2.

[54] Later chapters will detail how the nursing process was used and discussed in nursing.

process is a concept embedded in knowledge and practice; nursing process development also mirrors professional development in nursing.

What is the nursing process?

Since the 1950s, several nurses presented and posed the question: what is nursing's function? Nursing started to be seen as a process influenced by scientific developments. In turn, influenced by these developments, the role of nurses and their functions were topics discussed frequently. In this section, the view of the North American nurses who first discussed nursing as a process are outlined. The subtle differences in their uses of the term will reveal how nursing viewed its meanings. Discourses of nursing definition as 'nursing process' described in U.S. earlier than other countries and texts remains I use these texts to analyse how nursing process talked as these discourses influenced on the Australian nursing later on.

First appearance of the nursing process

The term nursing process was not common until the mid 1960s (Yura & Walsh 1983, p. 18), although there is some limited documentation of its use in the 1950s. Potter and Perry (1985, p. 128) are authors of a nursing textbook called *Fundamentals of nursing: concepts, process, and practice*. In the chapter 'Overview of the Nursing Process', they show that the nursing process was first introduced by Hall (1955). When she addressed the topic of 'Quality of Nursing Care' to a meeting of the Department of Baccalaureate and Higher Degree Programs of the New Jersey League for Nursing in 1955, Hall addressed the definition of nursing as her topic and said (Hall 1955, p. 213):

> Now that we have determined what constitutes nursing, we may turn our attention to the quality of nursing care. The assumption underlying the following discussion differs from the one which sees nursing as a range of functions proceeding from simple to complex ones. It sees nursing as a process. The quality of this process may range from not so good to very good.

Her statement, 'Now that we have determined what constitutes nursing', implies her confidence and argues for nursing as a discipline with a knowledge framework. She points to a direction for improvement. She suggests that nurses need to look at

nursing explicitly by focusing on the relationship 'in' and 'with' nurses and clients. Hall also wrote about the importance of other prepositions (1955, p. 215):

> In the "at" and "to" nursing, it is nice but not necessary to understand the patients; in the "for", it helps to understand the patient in order to "manipulate" him [sic] better.

Thus, nursing process at its first appearance emphasised the quality of nursing 'in' and 'with' the clients as individuals. Hall described nursing in 1963 as being influenced by medical technologies. Hall (1963 p. 805) stated with regard to medicalisation of hospitals:

> Fifty years ago, patients entered the hospital for hospice, for the care that the family could not provide in the home setting. That care was nursing, because medicine at that time had little more to offer in the hospital than in the home. Today, we have an explosion of medical knowledge, skills, and techniques. Many services are so expensive, specialized, and complex that that they must be concentrated in the hospital. Patients come to hospitals for the medicine offered there. They come to medical centres. The chief emphasis of hospital care is medical.

The problem of nursing being taken over by medical technology, made Hall question further the definition of nursing. Hall thought that the essentials of nursing are based on the relationship between patients and nurses and nursing is about caring for these patients. Hall also presented her nursing ideas about post-acute phase patients (Yura & Walsh 1988, p. 44). She noted three components: care, core and cure. Medical technology according to Hall (1963, p. 805) was changing the nurse's role:

> Physicians, in short supply, have delegated more and more medical practices to her, and she has, in fact, become a "practical doctor." With the increase of her delegated and accepted responsibilities in medical *curing*, she [nurse; sic] in return has had to delegate many of her responsibilities in *caring*…

Hall did not deny the important responsibility of technology in helping to care for patient. However, she emphasises the caring aspects of the medical profession, i.e. both doctors and nurses. She explains that the 'busyness' of nurses with responsibilities such as diagnostic procedures and critical medical care meant that patients experienced 'practical doctoring' rather than 'practical nursing' (Hall 1963, p. 805). Hall stated, "This, I believe, may be the basis of his [doctor], the nurses... (p.

805)” and the public's negative reactions to nursing care as it is given today'. Her opinion regarding 'practical doctoring' by nurses implies that nurses tried to legitimise their roles by extending medical knowledge via nursing. This positions nurses to take over some skills that medical doctors perform and integrate medical knowledge into nursing to create own knowledge.

The article is about the newly opened Loeb Centre for Nursing and Rehabilitation established on the concept of a patient-centred care and nursing, in which Hall strongly believed, at Montefiore Hospital, U.S. in 1963. Hall (1963) stated that the centre's value for nursing education was "self-evident. With early field experience in a centre where nursing rather than medicine is emphasized, the student may emerge a nurse first". Hall's way of defining nursing in texts is different to that of Orlando's who investigates 'good and bad' nursing (Orlando's nursing definition will be discussed later). Hall sought to describe the function of nursing by focusing on the relationship between nurses and patients as different to that between doctors and patients. Although Hall did not use the terms assessing, planning, implementing and evaluating in her 1955 and 1963 articles, she did refer to evaluation for the process of nursing. She wrote that the most valid way to evaluate the quality of nursing is in the process of nursing itself. For example, valuing the relationship between nurses and patients with a focus on care, rather than expecting the problem to be solved and better outcomes through technology.

Potter and Perry (1985) describe Hall as the first person to introduce the nursing process, but according Meleis (1997), the nursing process was firstly introduced by Orlando in 1961. It is not my aim to determine the first person to introduce nursing process but suffice to say that Potter and Perry explain that Hall (1982, p. 129) saw nursing as a process for the first time. The function of nursing was not clearly defined in the 1950s as Hall had stated and she found describing the nursing function to be a challenge. The 1950s was a decade of change for nursing as medical technology continued to develop and became part of the concept of 'cure' in medicine. The duties of nurses were increased due to medical devices although there was poor preparation to manage these medical devices. Thus, this period was marked

by nurses seeking to develop their transitional role by taking over the various medical tasks that used to be the doctors'.

It is not clear how Hall (1955) influenced Orlando's thinking. However, it is clear that nurses and nurse educators particularly in the U.S. were keen to define the function of nursing at this time. Orlando (1962) said at the last graduating class of the Flower Fifth Avenue Hospital in 1962:

> Your identity as a professional nurse stems from a clear idea of your function. That is to say, what do you do or what is your job or more importantly, what is your professional responsibility? If I could ask each of you now what is your function? I don't know what you would say…Without knowing exactly how you would describe your function, I'm relatively certain that to this you would agree.

Orlando (1962) claimed the importance of function and responsibility as a profession in her speech. She believed that the nursing profession is valued in the U.S. society and nurses take responsibility for their actions. Although Orlando did not mention accountability of nursing professionals, the speech of 'knowing exactly how you would describe your function', shows the notion of accountability in nursing profession. Moreover, Peplau (1988) had discussed the nurse-patient relationship earlier than Hall and Orlando in her book *Interpersonal Relations in Nursing* (originally written in 1952). She sought for the role of nurses while she tried to find out what the nurse-patient relationship is. Peplau wrote (1988, p. 43):

> …Society has views on how nurses should function and these conceptions vary in communities and economic groupings. Professional literature promotes pictures that influence nursing; textbooks on professional adjustments traditionally suggest patterns of behavior that indicate nursing roles…

She was conscious of the relationship between society and nursing and that nurses needed to seek their own roles. To answer her questions, Peplau (1988) identified four phases of the nurse-patient relationship (see Diagram 11).

| Orientation | Identification | Exploitation | Resolution |

The direction of nursing care
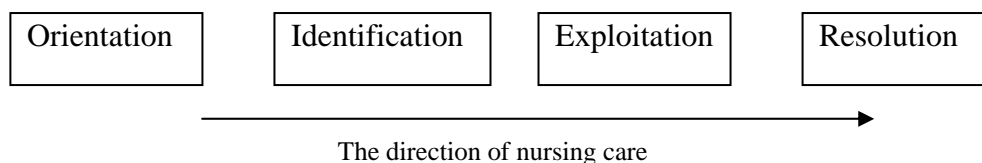
Diagram 11: The four phases of the nurse-patient relationship by Peplau (1952)

This phase starts from the phase of 'orientation', in which the nurse and patient establish the relationship and redefine and clarify the existing problem (Peplau 1988, p. 30). Then the phase of identification and exploitation follow. These phases allow the patient to realise their capability to handle problems with available resources and find ways to resolve the problem. The last phase, resolution is about ending the therapeutic relationship between a nurse and a patient. In their textbook, Potter and Perry (1985, p. 7) explain that the most important purpose of nursing according to Peplau's argument is to educate the client and the family to reach mature personality development. Her explanation emphasises the relationship between clients and nurses and "as the nurse-client relationship develops, the nurse helps the client identify the problem and potential solutions". Peplau's description of problem identification is more sophisticated than the 'problem-solving' of the nursing process (Yura & Walsh 1967) which appears to exclude the patient and deal with known solution to known problems. From the 1950s through to the 1980s, the debate over what is foundational to nursing emphasises the relationship between patients and nurses.[55]

Orlando's influence on the discourses in the nursing process

The concept of nursing based on the relationship between a nurse and patient influenced Orlando (1961) to publish *The Dynamic Nurse-Patient Relationship: Function, Process and Principles*. She participated in experiences with patients, students, nurses, and service personnel. Through her observations and analysis of the stories of the interactions between patients and nurses, she found that she could distinguish between 'good' and 'bad' nursing (Schmieding 2002). Orlando pointed

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[55] An article by Brown (1964) argues that the need for nursing theory is based on scientific knowledge and she emphasised expanding the theory of patient-centred care.

out that the good nurses listened to patients and tried to end the patients' distress. For Orlando (1961) what occurred in a nursing process focuses on explanations as to what and how a nurse should act to deliver 'good nursing' (Orlando 1961). In other words, the quality of nursing being delivered is central to Orlando's portrayal of good nursing.

Orlando (1961, p. viii) explained the purpose of her book was to "offer the professional nursing student a theory of effective nursing practice. It is hoped that the application of this theory will help the student develop her professional role and identity". The aspect of 'nurses as a skilled and good person' was more important to explain nursing, with the emphasis of the skill of 'observing'. Orlando's nursing process explained the way to establish nursing knowledge by focusing on the nurse-patients relationship in terms of 'good nursing', which gave insight to nurses and nurse educators about theorising nursing as a discipline.

Orlando (1961, p. 36) explains the three elements of nursing process in her book: the behaviour of the patient; the reaction of the nurse; and the nursing actions which are designed for the patients' benefit (see Diagram 12 in next page). She explains that the interaction of these elements makes up the process of nursing. Orlando describes nursing elements each of which contributes to the creation of nursing. For example, a patient's behaviour influences a nurses' immediate behaviour in observing the patient. The purpose of nursing can be characterised by nurses observing their patients. The second element is nurses' reaction towards a patient's behaviour. The third element of nursing is "any action the nurse carries out" (Orlando 1961, p. 60). In other words, Orlando's nursing process is more about 'the process of nursing' and the focus of the study is on nursing activities carried out in direct response to the nurses' reaction to a patients' behaviour.
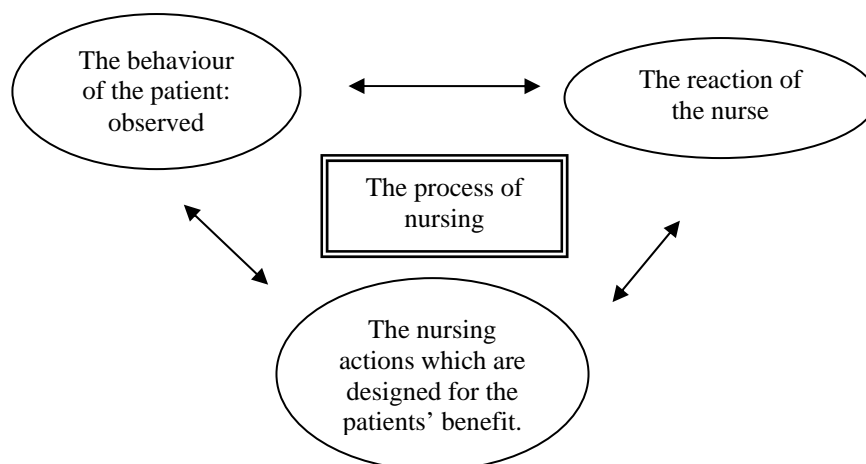
Diagram 12: Orlando's three elements of nursing process

Theorising nursing by Orlando

Orlando tried to theorise 'good nursing'. One of the elements of profession according Potter and Perry (1985, p. 28-9) is to "has [have] a theoretical body of knowledge leading to defined skills, abilities, and norms". Such a process undertaken by Orlando can be viewed as using these discourses to frame what and why discerning nursing knowledge was a central plank in its professionalization agenda. Although there is no text showing the motivation of theorising good nursing by Orlando, she tried to prove 'good nursing' based on evidence from her research. Schmieding (2002, p. 316) wrote that "Orlando's theory remains one of the most effective practice theories". Orlando's theory supports what is 'good nursing' and Schmieding (2002, p. 316) further explains 'good nursing' happens when:

> …the nurse found out what was happening and identified the patient' distress. The nurse found out why the patient was distressed and recognized that without the nurse's help, the patient could not relieve the distress.

Orlando (1961) describes distressful situations for patients and how nurses react and act in these situations. She explains how to identify good and bad nursing (Schmieding 2002, 2004). When Orlando observed nurses caring for babies in hospitals, she saw one nurse settle a baby and another nurse who did not, so that the baby started crying again. She categorised the former case as good nursing and the latter case as bad nursing. Orlando believed that good nursing and bad nursing were

situated along a moral continuum and are judged by nurses in terms of what is morally expected for nurses to care for the sick. Orlando asked various people such as nursing students, nurses and nursing professors to categorise cases into good and bad nursing and collated them. All the cases were categorised in exactly the same way as Orlando. Based on this categorisation, she found that there was agreement about what good nursing is or bad nursing is. For example, bad nursing occurs when the nurse does not observe the patient properly, does not know what the patient wants and does not intervene in such a way that the patient's health status improves. Orlando's process of nursing is based on her investigation of good nursing, which also describes nursing in a scientific (research-based) manner. This scientific theorising of nursing had not been done before, and its importance lay in providing a way to control the internal uncertainties of nursing.

The following table summarises the thinking about nursing by authors whom have been discussed previously.

Table 1: Nurses who described nursing in the 1950s and the 1960s

The person who described nursing	The context of nursing	The description of the relationship between nurses and patients	Explanation for process of nursing
Peplau (1952)	The important purpose of nursing is 'to educate the client and the family to reach mature personality development'. Her nursing explanation emphasises the relationship between the clients and the nurses and 'as the nurse-client relationship develops, the nurse helps the client identify the problem and potential solutions'.	The relationship between patients and nurses is the central idea for nursing	She did not mention the process of nursing. Her emphasis is on the relationship between nurses and patients. Moreover, the goal of nursing states that the maturity of the relationship promotes patients' and nurses' inpendence.
Hall (1955)	She sees nursing's function is constructed by the intimate bodily care (such as bathing, feeding, toileting, positioning and	She describes the four prepositions; 'at', 'to', 'with' and 'for' which reflect different approaches	She did not mention a systematic process, but she wrote that it is the nurses' ability to evaluate the patients' outcome on

	moving), sharing medical care and responsibility in using the relationship for therapeutic effect.	to the nurse-patient relationship.	discharge with her 'observation of the process itself'. Nursing itself as a process best enacted as nursing 'with' patient.
Orlando (1961)	Nursing process firstly focuses on planations as to what and how a nurse should act to deliver 'good nursing' and its focus is more on the value of nursing. [Research-based study]	Her emphasis is on the reaction of nurses according to the patients' behaviours. These interactions create the process of nursing.	She did not explicitly mention the four steps of nursing process as described by Yura and Walsh. She states that her motivation to write the book is for teaching the foundation of nursing for nursing students. By theorising good nursing, she tried to establish nursing as a unique discipline.

All considered the process of nursing in a period in the U.S. when nursing was seeking to define itself and its primary function separate to medicine. Yura and Walsh took a different view, influenced by the increasing dominance of science.

Yura and Walsh's nursing process as nursing rationality

Yura and Walsh published *The nursing process* in 1967 and it continued to be revised until the last edition in 1988. The first edition of *The nursing process* is based on the proceedings of the Continuing Education Series conducted at The Catholic University of America in April, 1967. The Continuing Education Series was conducted annually from 1964 and each year covered topics such as nursing in cardiovascular disease, nursing in neurological conditions, and so on. In 1966, the topic changed from a focus on disease, to a focus on nursing more generally: "The nurse, The patient, The illness". The dynamics between patients, illness and nurses became the focus of study.

The term 'disease' changed to 'illness'. Disease is more about abnormality in the human body, but the more personal aspects are more likely to be absent from the word 'disease'. The focus of this term is in the context of disease such as what kind of disease, how it happens, and so on. These interests belong to medical doctors but

there was little interest shown in the psychological reactions of patients. On the other hand, the term 'illness' explains people's state of unwellness. This word is more about people and not the disease. These changes reflect a change in nursing focus from 'disease-oriented' nursing to 'patient-oriented' nursing. The change reflects the shift in definition of nursing from nursing as a sub-discipline of medicine to an independent discipline. Their book considers the nursing process in terms of assessing patient needs, planning to meet patient needs, implementing a plan of care and evaluating the plan of care (see Diagram 13 below).

Assessing patient needs	Planning to meet patient needs	Implementing a plan of care	Evaluating the plan of care

The nursing process ⟶
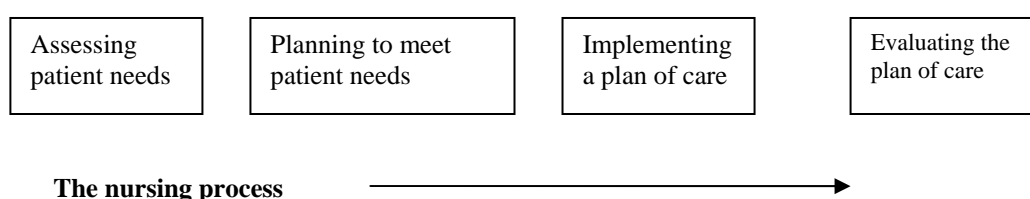
Diagram 13: The nursing process by Yura and Walsh

Yura and Walsh (1967) wrote in their in introduction:

> The nursing faculty members responsible for planning the 1967 Continuing Education Series agreed that The Nursing Process is timely topic and is a broad topic which lends itself to a variety of teaching approaches. [56] One means of defining the elements of nursing process is to assess the needs of the patient, develop a plan of care to meet his needs, implement the plan of care, and evaluate the extent to which the plan of care has provided for meeting the needs of the patient. This was the approach to the nursing process agreed upon (p. iv).

Each step of the nursing process was explained by different authors. In the last chapter called 'Application and summary of the nursing process', Yura and Walsh talked about the nursing process (1967, p. 114):

> Necessarily, you see the nursing process in a completely different light when you are facing many responsibilities in the patient situation than when you talk about it, reflect upon it, in a classroom setting such as this. It is necessary to move away from the daily pressures of the work situation on occasion, however, to get another perspective of what you are doing. A

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[56] 'The Nursing Process' is underlined by Yura and Walsh.

> deliberate, conscious awareness of the nursing process could
> possibly have changed this reported situation.

In their summary, it seems that there is an expectation for nurses to reflect on their practice and implement the framework-based nursing. By doing so, it gives nurses to have another insight into how to reduce their busyness in practice. In contrast to the work of Peplau, Hall and Orlando, they did not mention the relationship between nurses and patients and their focus is on organising and systemising nursing in practice. Their nursing process's emphasis is on the organisation of nursing tasks.

In the second edition of the book (Yura & Walsh 1973, p. 31-51), no mention is made of nursing theorists' names are mentioned but in the fourth edition in 1983, theorists such as Nightingale, Hall, Peplau, Henderson, Orlando and others are acknowledged. Yura and Walsh (1983, p. 32) explain in the fourth edition of the book:

> The influence of these pioneers continues to be felt to the present
> day. In addition, increased numbers of nurses became visible and
> their writings became more prolific. The acceleration of ideas,
> research, simulation, and challenge began as a rumble in the 1950s
> with the ideas and efforts of Hildegard Peplau and Lydia Hall.

Yura and Walsh acknowledged this work but did not use their work to construct theory of the nursing process. Rather, writing about see the pioneers was for Yura and Walsh, to indicate the direction of nursing, which meant theorising nursing. Until the third edition of their book editions (published in 1967, 1973 and 1978), Yura and Walsh concentrated on presenting their nursing process. It was the fourth edition that they described the theoretical framework for the nursing process in Chapter 2 and explained that the theories supporting the nursing process, "include general systems theory, theories of human need and perception, information theory, communication theory, and decision and problem-solving theories" (1973, p. 71). It could be a legitimatisation process for Yura and Walsh to claim that their nursing process was applicable to theories while seeing the trend of nursing knowledge development (theorising nursing) by other nursing theorists.

I consider that as a result, this activity influenced Yura and Walsh who in the 1988 edition (1988, p. 45) explained Peplau's recognition of nursing:

> as a process that "demands certain steps, actions, operations, or performances that occur between an individual who does the nursing and the person who is nursed." It is a therapeutic, interpersonal process in which nurse and client share in the solution of problems.

Comparing Yura and Walsh's perspective to Peplau's writing about nursing practice above, Peplau (1988) has a focus on the interpersonal relationship between a patient and a nurses, whereas Yura and Walsh's perspective was more about organising the tasks of the hospital to deliver high quality nursing. For example, the solution of the clients' problems in the Peplau's context is shared between a patient and a nurse. In the Yura and Welsh's context, nurses assess the patient's problems and implement the care plan for a patient. Yura and Walsh (1983, p. 298) believed that deliberate use of the nursing process will result in:

> Improved history taking; more accurate nursing diagnosis; more effective priority setting; improved design of nursing care plans…more emphasis on evaluation as well as on the development of tools for evaluation…all are the goals of the continuing development of the nursing process.

The text does not mention the patients' perspective and the emphasis of the nursing process is on the effectiveness and accuracy of the process in practice. Followed this, Yura and Walsh believed that:, "Increasing the accuracy in problem solving and in predicting the impact on client behavior are important factors in experiencing success in nursing practice" (1983, p. 300). The text again does not mention patients' perspectives and finding the solution of the problems is not shared with them. The emphasis on the use of the nursing process is on the positive outcome of the process, seen as solving patient problems.

The introduction of nursing process into Australia

After the Second World War, the number of medical institutions increased due to the rising population, especially older group. Due to the imbalance between the hospitalised population and the workforce who cared for them, the existing quality of

nursing was questioned (in the USA), for example by Hall in 1963. To supply the workforce the number of nursing schools was increased. In addition, there was a large shift of nursing education to higher education for more nursing students in the 1960s in the USA. In nursing practice, due to medical technological developments, the duties of nurses increased in terms of nursing care and responsibilities. This expansion of the role of nurses encouraged them to rethink their role. It was also the era when nurse educators and nurses started to think about nursing education as the province of nurse professionals.

In this atmosphere, Orlando's nursing process theory was explored in more detail in the nursing literature by nursing scholars. In the early 1960s in the USA, discussions about nursing education were active. This phenomenon influenced nursing and nursing education in other countries. International nursing educators went to observe and experience the American nursing education system, Australia being one of them. Heather McKenzie, an Australian nurse who gained a Fellowship grant from the World Health Organisation, observed schools of nursing and training in the United States. McKenzie wrote a report entitled *Report on overseas nursing education: 1965-1966* and made recommendations for the nursing education system in Australia. According to Emmanuel (1993), in Australia, the first appearance of 'nursing process' occurred in an article 'What's new for nurses - part 2' by Slater (1963). Although the term nursing process was not used, the process she explained all.[57]

Slater is an Australian nurse educator and had worked and studied in several countries such as USA and UK Slater studied at the University of Washington in 1959 for a Bachelor's degree and Master's degree in 1961 (The University of Melbourne eScholarship Research Centre 1994). She experienced the discourses of nursing process in the 1950s and the 1960s in the USA. When Slater presented the process of nursing in her paper in 1963, the term 'nursing process' did not appear in

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[57] Taylor and Game (2005, pp. 110-1) wrote, "on her return [from the USA], she introduced the Nursing Process through the Royal College of Nursing, Australia, which was then the College of Nursing, Australia". Chris Game, who was the co-writer of this chapter, experienced the changes herself while working with Pat Slater (Taylor B, 2007, pers. comm., 5 June).

the public sphere although some people expressed the view that 'nursing is a process'.[58]

Slater (1963) wrote a two-part article emphasising the importance of teacher education for a student-centred programme and students' right to study and not be part of the workforce at hospitals. Slater (1963, p. 155) believed that the student-centred programmes also promoted the students' ability to provide better nursing care for patients. She emphasised that systematic organisation in hospitals could provide better patient-centred nursing:

> …different patterns of staff organization planned to meet the separate needs of individual patients, and an entirely different emphasis in teaching and supervising student nurses, must be introduced if we are to give the sort of nursing care of which we were potentially capable (p.156).

She introduced the nursing process steps suggesting the following procedures for teaching nurses and organising nursing services:

> Firstly, the individual nurse, or the team in conference, assesses the nursing required by every patient for whose care the nurse or team is responsible….Secondly, the nurse prepares a written nursing care plan.[59] This takes into consideration the patient's immediate need for physical care, for emotional support, and for assistance from nursing personal in solving social problems associated with his illness…Thirdly, the nurse performs the procedures and gives the care outlined in the plan, and as she cares for the patient, she evaluates the effectiveness of the nursing she gives in terms of the progress the patient is making towards the previously determined goals. Fourthly, she revises her nursing care plan on the basis of this evaluation, and on the basis of knowledge gained about the patient his condition, and the care he needs.

As mentioned previously, Slater (1963) did not use the term nursing process and she may have already realised how use of the nursing process could influence nursing

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[58] For example, Hall (1955) and Orlando (1961) (see Table 1, pp. 101-2) explained that nursing as a process.

[59] The term 'nursing care plan' is only used in the phase of implementation by Wesolowski in Yura and Walsh (1967)'s book. Wesolowski also referred the Orlando's process of nursing in terms of implementation. Although she explained the phase of implementation, she did not explain nursing care plan as a whole process as Slater did in her paper.

education. [60] The nursing process could affect nursing students' flexibility in thinking.[61] Slater was writing in a period when nurses were employees, had limited education and were highly supervised in their task-oriented nursing. In this situation, Slater may have been afraid that applying the nursing process step-by-step would end up as nurses and nursing students providing 'rigid' and 'automatic' nursing, which Orlando defined as 'bad nursing'. Hence, Slater's statement "an entirely different emphasis in teaching and supervising student nurses" can be understood as her attitude on the side of caution. Orlando and the Slater agree in their approach to nursing process.

Taylor and Game (2005, p. 120) explained that the nursing process in Australia went through a process of 'resistance', 'acceptance' and 'institutionalization'. It is unclear how Slater perceived this process and started to use 'the nursing process' in later years. She mentioned the changing role of nurse and talked about the process implicitly in a speech at the Southern Memorial Hospital in 1969:

> Observing, reporting and recording the patients' condition…Third important area of nursing responsibility is that of observing the patients' changing condition, and within the limits of the nurses knowledge, assessing significance of what she observes and deciding on appropriate course of action – what some writers call making a nursing decision.

Slater was an extremely important pioneer in the development of nursing and nursing education in Australia. Slater (1969) is linked into the North American nursing discourses. A different interpretation of the nursing process is also argued by de la Cuesta (1983). She investigated the nursing process in the UK context, she states, "In the UK the nursing process did not grow autonomously: it was taken from the USA in 1970s and then disseminated" (de la Cuesta 1983, p. 367). Nurses debated how the nursing process fitted into UK nursing practice. One of the reasons why the UK nurses accepted, with alteration, the nursing process was that nurses were not

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[60] Slater's article appeared 4 years before the publication of Yura and Walsh's book. It can be assumed that discussions were occurring in the U.S. about Hall and Orlando's views and the more problem solving approach by Yura & Walsh. Slater's description has elements of both emphasising on observation and reaction close to Orlando and steps reflect Yura & Walsh.

[61] See the reaction of nurse educators when the nursing process was introduced in the nursing school (see Chapter 6, p. 183).

satisfied with the existing system of the delivery of care in UK and concluded that the nursing process could help achieve the quality of care in practice (de la Cuesta 1983, p. 367). In the case of Australia, Slater (1963) talked about the nursing care plan steps without mentioning the nursing process. Thus, these arguments about the nursing process show the conflicts between ideological and practical uses of the nursing process in its process of acceptance into certain parts of nursing (Taylor & Game 2005).

The different focus in nursing process

Orlando's definition of nursing process and another definition of the school of nursing of The Catholic University of America (Yura 1973) have different emphases. Orlando's focus is on the relationship between nurses and patients but not the implementation and evaluation of, which focuses on the reaction of patients. In contrast, the definition by The Catholic University of America included the after-process of care delivery to patients. Orlando aimed to educate nursing students "to offer the professional nursing student a theory of effective nursing practice…the application of this theory will help the student develop her professional role and identity" (1961, p. viii).

On the other hand, Yura and Walsh sought to improve nursing care by implementing their nursing process in hospitals. The two different streams regarding nursing process discourses are observed here. One focuses on improvements in nursing education while the other emphasised improvements in nursing care. Hall and Orlando's main ideas are situated in the relationship between patients and nurses, not as a problem-solving process framework for nursing. What made their claims different from the later work of Yura and Walsh?

Some answers can be considered. One is technological development, which changed the role of nurses dramatically. Another answer is the increasing influence of science in nursing. These influences indicated a shift in the values of nursing. The two different levels of nursing process discourses indicate the influence of this trend. The different concepts in nursing process will be discussed in later sections.

Towards a science of nursing and the problem of technical rationality

O'Connell (2000, p. 92) explained   ` two elements that promoted problem solving based nursing process in nursing. One is an emphasis on problem-solving to reduce uncertainty in nursing knowledge. The other is the reduction in uncertainties to generate nursing professionalism and accountability.

The problem-solving approach and nursing knowledge development

The concept of the nursing process changed from Yura and Walsh's (1967) first explanation. In the fifth edition of their book, Yura and Walsh (1988, p. 25) wrote the benefit of using the nursing process is as follows:

> Systematically addressing client problems by way of the nursing process is a series of deliberate actions directed toward the resolution of actual or potential problems. There is unquestionable merit to this more scientific and structured process of problem solving.

Their definition of nursing process refers to a problem-solving approach. A method of seeing a problem in nursing, especially in patient care, started with defining a patient's illness as a problem. In other words, patients' bodies are problematised. The problems are patients' bodies and were to be solved with medical technology, such as operations, and electronic equipment. In this sense, problem-solving became an illustration of scientific problem-solving. Schön (1983, pp. 21-2) criticises too great an emphasis on scientific problem-solving as technical rationality. He writes:

> …professional activity consists in instrumental problem solving made rigorous by the application of scientific theory and technique. Although all occupations are concerned, on this view, with the instrumental adjustment of means to ends, only the professions practice rigorously technical problem solving based on specialized scientific knowledge.

Emphasising problem-solving skills based on scientific knowledge has narrowed professionals' view to only to see the means and ends where it was assumed there was agreement on what the problem was. In the technical rationality perspective, "professional practice is a process of problem *solving*" (Schön 1987, p. 39). This process neglects the context of a problem. In a real life situation, problems are not

clearly defined and a practitioner needs to define what the problems are. The scientific approach to the patients' body also saw nurses "turning away from 'traditional body work' to technology work in nursing" (Sandelowski 2006, p. 112). Nurses' work is originally based on the relationship between a patient and a nurse and nurses. This relationship is taken over by technological development and nurses chose to possess techniques to be professionalised.

Reducing uncertainty and building accountability in the nursing profession

Regarding power and professions, Light (1979) states that there are more uncertainties in training that relate to the learners' environment and the relationship between learners and clients. Light built on the arguments of Fox (1957). Fox (1957) argued about the uncertainties in the learner's knowledge environment. Three uncertainties in knowledge are described. First, the learners know that their knowledge is imperfect. Second, learners realise that professional knowledge itself cannot be determined precisely. Third, learners are not able to make a distinction "between imperfect mastery of available knowledge and imperfections in the knowledge itself" (Fox 1957 cited in Light 1979). Light (1979) focuses on the relationship between learners and their environment. He explains the uncertainties surrounding learners – mentors and teachers, diagnosis, treatment and clients' responses. Light's argument is that uncertainties exist not only in the learners' knowledge but also exist in the learners' surroundings. Light (1979) believes that practitioners will learn how to control uncertainties by becoming more competent in their clinical experience and as practitioners learn to control such uncertainties. In the discussions about the development of nursing process, this constituted a way of finding certainty in nursing. Through finding certainty in nursing, nursing is able to control and manage what it could not previously. As Light (1979) explained this was not without risk:

> Thus in gaining control over their work by acquiring a treatment philosophy and exercising individual judgement without question, professionals run the danger of gaining too much control over the uncertainties of their work…Their emphasis on technique can make them oblivious to the needs of clients as clients define them; yet it is clients' trust that professionals will solve their complex problems which provides the foundation of professional power (Light 1979).

Light's argument here is a precursor to that of Schön (1983). For nurses, the nursing process was a way of gaining control over uncertainties in practice but was to be criticised for its 'technical rationality'. O'Connell (2000) highlighted the two elements that influenced nursing process by citing Street's work. Nursing started to possess a culture of writing as a common language that did not exist previously (Street 1992). Discourse writing about nursing was also professionalisation agenda while nursing established legal accountability. For example, the role of nurse in the competency standards (ANMC 2006a) and the code of ethics of nurse (ANMC 2002). Street (1992, p. 18) described the relationship between writing culture in nursing and its activities in practice in the following way:

> Clinical nursing has been formed through an emphasis on the development of oral skills. An examination of the conduct of clinical practice readily discloses a basic premise that the expressive capacity of oral communication leads to knowledge development which is passed on and developed orally through a number of nursing structures.

The used of the nursing process had the potential to promote nurses' writing for practice, but writing was "designed to undermine the power of the oral culture and the medical and task-based recording styles of past nursing practices" (Street 1992, p. 19). She also claimed that this differed from medical culture, which possesses a written culture based on facts that doctors pass on to others. O'Connell and Street claim that nursing as a discipline started to have a writing culture, nevertheless there were advantages and disadvantages in using and implementing this in nursing practice. In teaching nursing, it proved useful for teachers to give a framework for the teaching of nursing. This was not without debate as the linear conventionalised way of using the nursing process also created controversy in teaching nursing.[62] This process of divergence in how the nursing process was thought of will be discussed in the next section.

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[62] The arguments about the implementation of the nursing process in the curriculum will be discussed in Chapters 6 and 7.

What do the two concepts in nursing process imply?

There are no clear indications of the relationship between Orlando's work and that of Yura and Walsh's (1988, p. 66). It is assumed by Yura and Walsh that nursing process is to be explored in nursing practice rather than nursing education. The second edition of *Nursing Process* was published in 1973 and Yura and Walsh (1973, p. 23) explain how nurses reacted toward it, "At present, the term nursing process is accepted by nurses and it is viewed as the core process by which the purposes of nursing are fulfilled". It can be assumed that those people eager to define nursing and needs from a nursing practice perspective accepted the nursing process as defined by these authors at the time of its introduction. Yura and Walsh (1967) aimed their idea of the nursing process towards nurses who worked in hospitals. Nursing in a hospital could fit a system of nursing process into institutionalised care practices. The *methods* of delivering care were regarded as key issues in nursing and textbooks included the terms 'care plan' and 'process' from 1967, as is discussed below. Textbooks were a way by which nursing education was influenced by these ideas.

The example of Lewis's work

Lewis (1970) published the first edition of a book called *Planning patient care* in 1970. She described the planning of nursing care as a nursing process involving the care for one person or for a group. Concerned with patient-centred nursing, Lewis (1970, p. vii) wrote, "An orderly, systematic way of looking at the patient's needs" is possible. In the first edition of her book, she does not discuss nursing process in-depth and she explains (p. v), "I realize that some part of the elements of a theoretical framework is missing and must await additional thinking and clinical trial". However, she explains 'the process' in the book and writes (Lewis 1970, p. 2):

> The process by which the nurse identifies, plans, and implements the nursing care of the patient is a problem-solving process which can be defined in three steps: assessment, intervention, and evaluation.

While she does not mention her process as nursing process in her first edition it does include the three of the same four elements in Yura and Walsh (1967). Lewis published her second edition in 1976 and she added:

> *Nursing process* refers to the orderly operations associated with all phases of providing nursing care. It involves the decision-making interactions and reactions, and the evaluation of responses that occur in the nurse-patient encounter (Lewis 1976, p. 1).

The definitions in the first and second editions differ (see also Table 2 in next page). The second edition mentions that nursing process is explained as a systematic approach to the nurse-patient encounter. Lewis (1976) describes decision making within the 'nurse-patient encounter', which implies interaction. Lewis's 1976 description of nursing process has some of the flavour of Hall and Orlando's process of nursing as well as that of the nursing process outlined by Yura and Walsh. The process also implies nurses' ability, with increasing autonomy, to decide on patient care, which was not considered in the previous edition. Lewis's view of nursing process is to provide effective nursing care. She (Lewis 1976, p. 8) also emphasises the changing nature of nursing due to more responsibilities in patient care such as giving parenteral injections, monitoring vital signs and undertaking physical examinations. Her explanation of nursing process occurring in the nurse-patient encounter encapsulates the changing nature of nursing. The increase in the number of responsibilities in nursing care also promoted the use of a nursing process in practice due to the rise in importance of technological procedures.

Table 2: Summary of the Lewis books

Author	Title of the book	The explanation of nursing process
Lewis (1970) First edition	*Planning patient care*	She uses the word 'process', but does not mention 'nursing process'.
Lewis (1976) Second edition	*Planning patient care*	She uses and explains 'nursing process'. The concept of responsibility brought about by technology development is added.

Bower (1972, p. vii) wrote a book titled, *The process of planning nursing care*, in order "to present a theoretical framework for nurses to enable them to plan holistically by seeing the individuals as unique clients". Bower does not use the term nursing process although she shows the four steps of planning nursing care: assessment, problem identification, formation of a plan and planning for evaluation

(Bower 1972, p. 10). One difference observed in Bower's book is that although she did explain the nursing process, she presents nursing care holistically. In Chapter 2 of her book, she explains that systematic planning of nursing care is a concern for effective quality care. 'Systematic planning of nursing care' implies a nursing process and this process is accepted. However, she does raise a question and challenges, as follows (Bower p. 25):

> For instance, even if the nurse knows the process, is there any particular approach that has a higher probability of success over any other? Is there an approach that increases the quality of care, that is, increases the quality of the interpersonal action? Is there an approach that effectively provides a humanistic means of meeting the client's needs? For no matter how knowledgeable nurses are about the process of planning care, unless they are able to implement it in some way that is satisfying to both the nurse and the client, the process is useless.

She continues to claim the importance of holistic nursing care based on holistic theory. Her argument is more like Hall's (1955) and Lewis (1976) too, stresses the importance of interaction with the patient. Although the arguments about nursing process become more active by the early 1980s, it is noticeable that Bower argued about nursing process from a holistic view in the early 1970s. When Bower (1972) wrote this book, she was involved in a curriculum revision project at California State University. This was an opportunity for her to consider what to situate nursing process in the nursing education curriculum.

Yura and Walsh's (1967) description of nursing process, influenced others who wrote after them. Their nursing process focused on a problem-solving framework and was based on their claim that nursing is a systematic process that goes beyond the relationship between nurses and patients. Thus, the concept of nursing process has developed along two clear and distinct lines, with some attempts at integration as seen by Lewis and Bower.

The implications of the shift from 'a process of nursing' to 'the nursing process'

In the debates in nursing at this time there are two definitions of nursing, in terms of process. One is 'a process of nursing' and the other is 'the nursing process'. The differences between 'a process of nursing' and 'the nursing process' are that the former expression does not specify the process of nursing and it implies more openness. The latter expression implies a specific problem-solving process and one that has been pre-determined and carried out systematically. Buus and Traynor (2005, p. 37) summarised the two perspectives. One perspective understands the nursing process within the nurse-patient relationship. The other perspective is to understand its use in terms of management. In the latter perspective, nursing is understood to manage within the linear process of nursing. It projects forward to the end of the process and is more likely to concentrate on completing the process and awaiting the result. This process is motivated by a problem-based approach that starts by identifying the problem, seeks solutions to the problem, implements solutions and evaluates the outcome. The process shows the influence of technical rationality. This process is generally applicable and can be used to control uncertainty. Buus and Traynor described this type of nursing process as follows (2005, p. 38):

> …there is a problem (need) to be solved (met). The process, knowledge of the process, is an organizing instrument for the nurse. Further, there is a distinct resemblance between a rational research process and this formulation of the systematic problem-oriented Nursing Process.

They point out that this nursing process is a managerial approach that can govern at a distance, while on the other hand the process of nursing approach is 'the concept about practice' that cannot be governed at a distance (2005, p. 38). The nursing process is a product of technical rationality, which was utilised in the institutions for care management including calculation of care cost. The process of nursing approach is used to teach 'the context of nursing' to nursing students, which was often caused confusion.[63]

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[63] Chapters 6 and 7 will discuss how the nursing process was used in curriculum.

The books written about nursing process in the early 1960s to the 1970s focused on the relationship between patients and nurses. When Orlando wrote *The dynamic nurse-patient relationship: function, process and principles* in 1961, her focus was on providing direction for nursing students to see the interactive process in nursing. However, by the mid to late 1970s, the terms 'nursing process' and 'problem-solving' appeared more frequently in textbooks' titles and their contents pages. The book by Yura and Walsh (1967) influenced the concept of nursing process for nursing practice. Buus and Traynor pointed out that how the nursing process is described the discursive object; they differentiate the links between someone's need and nurses' reaction (2005, p. 39):

> …The Catholic University nurses [who studied Yura and Walsh's nursing process] talk of 'client', 'problems' and only implicitly about someone doing nursing. The agent is written out of the sentence; the agent of nursing, someone doing nursing, has been removed, indicating a different way of articulating nursing compared to Orlando's view…

The agent of nursing was missing in the form of Yura and Walsh's nursing process. The agency of nurses removed from their process indeed and the agent is replaced with the process itself. In this atmosphere, the role of nurse was emphasised to be skilled having the problem solving ability. On the other hand, Hall and Orlando's process of nursing focused on the agent of nursing. Nurses and nurse educators came to more talk about 'nursing process' with the focus on a systematic problem-solving approach, rather than on the relationship between patients and nurses. The original meaning of nursing process was lost and there is no change seen how the nursing process differs from process of nursing. This discourse of nursing process was spoken about in nursing education, and including curriculum documentation will be discussed in later chapters. In nursing practice, the agents were talked in different ways in terms of nurses' work and will be discussed in the next section.

Shift in nursing focus from individuals (agent) to groups (structure)

As I argued about the concept divergence in nursing process, different interpretations influenced the way of thinking about nursing practice. I will explore below nursing process as interpreted in nursing practice and how objectivity was created. It is not my intention here to deepen the discussion of the different interpretations of nursing

process in terms of the 'Exelcare' system. However, the discourses of the nursing process and Exelcare system will show how 'technique' turned into 'technology' and begun to govern nursing practice. This shift also has similarities to the process of governing the nursing profession. In other words, the nursing process was used to motivate a nurse or a nursing student to provide better nursing care with patient-centred care. With the emphasis on improving problem-solving skills to process nursing, gaining skills was stressed in the relevant curriculum documents. It was a belief that nursing could be improved by problem solving and 'good nursing'. However, the process became a linear one and individualised nursing care was lost, as well as nursing becoming marginalised in this process (Buus & Traynor 2005, p. 33). Technolgy helped this process (technique of nursing process), a technology known as 'Exelcare'. It is a computerized package for measuring patient care needs introduced into South Australian hospitals. Its primary purpose was to measure and control the nursing workload. I will explain by using Foucault's perspective (1984, p. 61):

> …there was a veritable technological take-off in the productivity of power. Not only did the monarchies of the classical period develop great state apparatuses…but above all there was established in this period what one might call a new "economy" of power, that is to say, procedures which allowed the effects of power to circulate in a manner at once continuous, uninterrupted, adapted, and "individualized" throughout the entire social body. These new techniques are both much more efficient and much less wasteful…

The nursing process in nursing education and practice developed as a relationship between 'technological and economic development' and 'nursing'. The nursing process originally promoted nurses' thinking about nursing to provide better care, which was influenced by socio-economic factors. In other words, the nursing profession was influenced externally, say economically, and able to utilise its influence internally by gaining the skills to use tools and in turn influence external forces. Foucault (1984) uses the word 'individualized'; I use this when describing the nursing process being popularised in practice. The use of techniques becomes the 'norm' and customised in nursing practice. In South Australia, 'Excelcare', as I explained previously, was introduced in the late 1980s and fifteen major public hospitals used it by 1992 (Willis 2002, p. 224). The aim of 'Excelcare' was to

measure units of nursing care.[64] The precise numbers of units of care were supposed to provide the calculation for the required number of nurses for an efficient and appropriate workforce. It aimed also to estimate nursing salaries that made up one third of hospital budgets at the time (Willis 2002, p. 225). Although the unit of care was measured and seemed to indicate the relationship between nursing workload and amount of care, there was resistance from ward nurses who complained about the inaccuracy of this unit. Nursing is a service for people and there are different person-to-person needs. Individual care needs are variable and not entirely predictable. This system institutionalised nursing as having one correct solution for problems. The opposition to Excelcare in nursing practice was over its effectiveness and accuracy. I used the example of Excelcare and quality discourses in nursing to show how the shift from technique to technology occurred in nursing using what had firstly been a way to develop nursing and its knowledge to a way of managing and organising nurses' work. The operation of technology within the nursing profession emphasised how uncertainty could be clarified by the use of a tool that could also precisely calculate nursing practice; it was also seen as a threat to nurses' control over nursing

Nursing demanded to be recognised as a 'science'

Technology influenced the shift in nursing from a focus on individuals to groups. In other words, its focus shifted from human interactions to system based interactions. There are two underlying factors relevant to this shift. One is that there is a professional socialisation process in nursing. Nursing can be explained in terms of a theoretical and practical framework. For example, Etzioni (1961) wrote that for professions to be considered as professions, they need to have a theoretical body of knowledge leading to defined skills, abilities, and norms. This point also leads to the second factor; the influence of scientific and technological developments in nursing. New inventions after the Second World War allowed medical technology to prolong human life. Nurses and nurse educators in the 1950s believed that nursing needed to use these technological advances. Johnson (1959, p. 219) wrote an influential article on 'the nature of science of nursing' and suggested:

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[64] Willis (2002, p. 224) explains this as follows: "Excel care is one of probably hundreds of nursing workload products, which vary from those that focus on "dependency levels" as the basis of their calculations to those…".

> Nursing today faces an important developmental task in the explication of its science. The scope and complexity of the knowledge which can be drawn from the basic and applied sciences makes it difficult to perceive and connect what is pertinent to nursing. The lack of a clearly defined, widely accepted specific goal for professional nursing further complicates the situation.

Johnson (1959) continued to argue about scientific knowledge becoming part of the nursing profession:

> The professional disciplines in general represent applied rather than basic sciences. They are committed to the task of utilizing knowledge to achieve some well-defined social goal. They draw heavily upon the basic sciences to derive their bodies of knowledge. They are sciences, however, and are concerned with the systematization of knowledge and with its expansion. These characteristics have very direct implications for the development of a science of nursing. The substantive content of any applied science is interdependent with the social goal of the profession which uses that science. The goal of nursing, both specific and shared, must be established in precise terms, therefore, to give direction to our search for a body of knowledge.

Johnson (1959) was one of the first nurse educators to address the need for science in nursing knowledge. In the 1950s nurses and educators were just recognising and trying to understand the relationship between science and nursing. The role of theory is to explain the phenomena that occur in the discipline. The need for nursing theory has been stated since nursing became recognised as a discipline in its own right. Nursing theory had not yet matured but in the 1950s and the 1960s nursing theorists were publishing articles. These articles discussed nursing theories as discourses of nursing knowledge.[65]

What is the 'true' aim of nursing process?

While the need for nursing theory has been discussed, the term 'nursing process' was not much seen in nursing education between 1961 (when Orlando's book was published) and the mid-1970s. However, Orlando's nursing process had a practical purpose. Orlando reissued and updated *The Dynamic nurse-patient relationship: Function, Process, and Principles* in 1990. In the preface, she wrote (Orlando 1990):

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[65] Although it is fair to say that many of the early theorists had a scientific view of nursing theory and were searching for a "grand theory of everything" in nursing. This quest was not abandoned until the 1980s (Meleis 1997, p. 43).

> If I had been more courageous in 1961, when this book was first written, I would have proposed it as "nursing process theory" instead of as a "theory of effective nursing practice". A "deliberate" process was presented as a guide for nurses to practice "effectively". Conversely, an "automatic" process was shown to be "ineffective"…

She implies that if nursing process was presented as a theory, misinterpretation would not happen in terms of the nursing processes. She explains (Orlando 1990):

> The term nursing process has undergone numerous redefinitions, and in some cases the definitions and descriptions pervert the original intent...However, I continued to develop and refine the formulations contained in this work. The "deliberative process" was renamed nursing process "with discipline", and the "automatic process" was renamed nursing process "without discipline".

For Orlando nursing process 'with' discipline can provide interactional nursing care between nurses and patients so that holistic care is produced. On the other hand, nursing process 'without' discipline (automated care) cannot provide interactional nursing care holistically. In this latter sense nursing is provided in only a shallow way, due to the lack of interaction and thoughtful application of nursing knowledge. According to Orlando, nursing process without discipline came to characterise nursing practice due to the demands and prejudices of organisational management.

In a desire to record and order nursing practice (as a part of the move to 'scientific nursing'), tools such as kardex files or computer systems for nursing care plans were introduced into nursing practice (Lewis 1970, p. 18). For example, Vitale et al. (1978) wrote in *A problem solving approach to nursing care plans* about the seven steps in nursing regarding problem-solving skills, i.e. data collection and its classification, deductions, nursing diagnosis, nursing hypothesis, hypothesis implementation and evaluation. They focused on nurses and the reactions of patients. The relationship between patients and nurses is omitted because the book's emphasis is on science without any input from a theoretical framework and it is a 'how-to' book of nursing. The interpretation of nursing process in their book is the one that Orlando describes as "automatic process". Dingwall et al. (1988, p. 213)'s discussion of the purpose of the nursing process in U.K. also pointed out how the nursing process was used as a vehicle. They described the discourses of the nursing process

by de la Cuesta (1983) and argued that the nursing process was the "one of the major vehicles" used by institutions to put responsibility of "a professional ideal on new entrants or those who passed through in pursuit of advanced training". This signals the conflict in the ranks of nursing academics and nursing authorities.

Chapter summary

This chapter has discussed how nursing process discourses developed and their background. The nursing process discourse highlights how nursing knowledge developed, with medical technology wielding a huge influence on nursing practice. The nursing process concept has been utilised in both nursing education and nursing practice, and was an important enabler of nursing's maturing as a profession.

Differences between nursing education and nursing practice in terms of nursing process have been demonstrated. Nursing process in nursing practice was utilised for quality assurance in nursing care as a response to 'technical rationality' influencing the professions. In line with the elements to be a professional, developed by Weber (see Chapter 2) nurses set the boundary of nursing professional practice by creating regulations for nursing practice. Nurses believed that this lead to accountability in nursing by applying a process employing the 'solution-known' process.

However, there were concerns about following only one type of nursing process that possibly excluded individuality and intuition, which are also an essential part of the application of nursing knowledge. It seems that the speed at which nursing process is absorbed into nursing practice was faster than nursing knowledge development in education settings. In this sense nursing process was welcomed in practice with the need to improve care management due to the expansion of medical institutions.

The first purpose for process of nursing was to deliver patient centred care, rationalised for use of nursing care management in hospitals. This shift in purpose was seen in medical knowledge development by Foucault, as technology rationality allowed doctors to see the patient reductionistically as a diseased body and to concentrate on the cure of the body. Nursing process as linear problem solving also brought this perspective to nursing, with the focus on the patient as a set of problems.

However nurses utilised the nursing process to gain professional status paradoxically using the technical rational approaches of medicine but excluding medical knowledge and power at the same time. In the next chapter, I will show how nursing process as a tool of nursing was integrated into the curriculum as the container of nursing knowledge and practice. The curriculum since the 1950s will be analysed along with the tools used in education.

CHAPTER 5

CURRICULUM AS A RHETORICAL VEHICLE

Introduction

Nursing has been described as a 'process', the 'process' symbolising the functions of nursing. The development of nursing process began with Orlando (1961). Later, the concept changed to reflect problem-solving applied in nursing practice by Yura and Walsh (1967). They turned the nursing process into a technique of problem-solving rather than 'nursing as a process' as suggested by Orlando. These different interpretations were used both in nursing education and nursing practice. The arguments for nursing process have also influenced the formation of nursing programmes. The development of arguments can be observed through the implementation of curricula and in how the nursing process was understood. It is my contention that these discourses indicate that there is a lack of precision in the concept and nurses were not clear about its use and the different meanings from its derivations in education or practice.

In this environment, how was the nursing process applied to curriculum? How did nursing education utilise the nursing process as the tool for managing uncertainty in nursing? I will analyse the arguments over 'nursing process' to describe nursing through curriculum development. The curriculum is perceived as a 'rhetorical vehicle' in this and this chapter draws on curricula in Adelaide nursing schools from the 1950s to 2007 to demonstrate this perception. Curriculum denotes 'rhetoric' when it contains ideologies about nursing/education and acts as a device to govern education. The variety of ideologies in nursing education and devices (i.e. the thinking tools for nursing) and how these were implemented in the historical curriculum will be described in more detail in Chapter 6 and 7. In this chapter, the change in how the curriculum was thought of over time, or how the curriculum has been understood within the nursing profession is outlined.

Curriculum and professional education

Nursing education is professional education. Due to the role of professions in society, each profession is partly defined by what constitutes them as an organisation. In the context of professional education, it can be said that there are two purposes for education. One is to achieve higher education.[66] The other is to obtain professional credentials. In this sense, the meaning of curriculum differs from other disciplines. A professional organisation also has power to influence professional schools. This is described by the project 'Professional Education and Credentialism'[67], in which the concerns of the educational institutions were stated as follows (Laver 1996, p. 101):

> The higher education institutions were concerned that the requirements of professional organisations for core content in professional courses impacted on the structure and content of their curriculum, and undermined their autonomy in respect of admissions to programs, and the way the curriculum is taught.

The dilemma of the educational institution is described explicitly: 'undermined their [higher education institutions] autonomy'. This depicts institutions as wanting to have more autonomy but being constrained by the requirement to provide education as regulated by the professional organizations; it implies that the professional academics had a sense of 'knowing better' what the professions needed in terms of education for the profession. This dilemma in professional education has long been argued over.

Increasing regulation of professional practice had an impact on the previous 'independence' of university courses. In Laver's 1996 publication, the introduction of competency-based education in the early 1990s motivated professional education to contextualise the competency and implement the concept into curriculum. NBSA is the nursing registration organisation in South Australia and has an ongoing role in curriculum accreditation. The report (NOOSR 1995, p. 29) made this clear:

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[66] It is in the context of higher education that the curriculum is talked about. Therefore, the context of professional education and curriculum is applicable since tertiary education for nurses commenced. It is the 1970s in Australia and in South Australia in 1975.

[67] This project is carried out by Higher Education Council, National Board of Employment, Education and Training in 1996, December.

> In the survey, registration authorities were strongly in favour of using NCS [National Competency Standard] to assist in developing curricula and assessment procedures at universities, perhaps because registration authorities rely on university qualifications as assurance of competence, in many cases without further testing.

The role of the educational institutions, especially in terms of the tertiary and higher educational institute, is not only "the autonomous institutions, but also accountable to the community for outcomes from their courses" (Laver 1996, p.1).

Hence, nursing does not only require a professional curriculum but also like professionals such as medicine and law needs to satisfy role expectations in graduates. In nursing, the relationship between hospitals and tertiary education institutions was influenced by the shift in 'who governs the school', when 'nursing training' gave way to 'nursing education', securing the students' position as learners. The relationship changes between the professional organisation and nursing school were discussed in Chapter 3 in terms of the changing relationship of power in nursing education in Australia. These two relationships will be analysed and described more closely below. Although the changes in 'the role of nurses' have been analysed in Chapter 3, I will briefly recap the argument about education methods used in nursing since the 1950s.

Need for educational methods change

Journals such as *The Australasian Nurses' Journal* and *The Lamp* were the major nursing journals in the 1950s and the 1960s in Australian nursing. In these journals, the discussions regarding nursing training reforms were intense. This period was marked by a dramatic increase in the tension between industrial aspects of nursing and nursing training. The demand for a bigger nurse workforce was high and there was a severe shortage of nurses. In Australia, the change in how the curriculum discourses occurred began in the 1950s, illustrated by discussions in the 1950s in 'The Curriculum and Nurse Education' in *The Lamp.* The article articulated the need for nursing education. Mudge (1956, p. 15) wrote:

> We now realise that true education means full development and
> growth of personality and abilities as well as preparation for life
> as a citizen. To accomplish this intra-curricular and extra-
> curricular activities must be considered. We need to recall the
> definition of nursing and understand the purpose of the
> curriculum in the preparation of the plan.

It was Mudge's (1956) belief that nursing needs to educate humanity and personal growth in nursing students. Moreover, she mentions revisiting the definition of nursing. However while there was a rising voice for change in nursing education and curriculum, it took some time before nursing education moved into the tertiary education sector in Australia.

In South Australia, the development of a Preliminary Training School (PTS) had been discussed before the war and finally was adopted at the Children's Hospital in 1947, and at Royal Adelaide Hospital in 1949, after a long discussion between the Nurses Board and the Hospital Board. The original letter from the Matron at the RAH to the Nurses' Registration Board (1947) described the structure of the school and salary for the lecturers and tutors. This course was prepared for beginners in nursing and it was also for those who started as nurses without any training. It also appears that the PTS course had some advantages for country hospitals, where it was hard to find students to be a nurse (Durdin 1991). Two assumptions were made about this new system. One was that it would create sufficient workforce in the hospitals and the other was that it would promote completion of the course, the drop out rate being relatively high in the training course (Durdin 1991, p.102). Designing this course was motivated by the desire to provide a better education but the main purpose was to retain students. Moreover, this interdependent relationship raised two key issues: the apprenticeship model as a nursing training system, and the relationship between medical doctors and nurses.

Apprenticeship model as the nursing training system

The first issue is the nurse 'training' system. The majority of articles on nurse education in nursing journals in the 1950s and 1960s discussed issues relating to the training system based on the apprenticeship model. Apprenticeship refers to gaining particular skills under the guidance of a 'master' and the term 'apprentice' implies

that nursing is not a profession. Gaining knowledge was portrayed as a 'hands on' and 'on the job' activity not one based on learning and reasoning. Therefore, the process of gaining knowledge and skill is regarded as mastering 'the procedures'. This training system caused a problem regarding the nursing students' status, and they worked for little pay.

In 1954, Miss Burbidge, who had studied for a Diploma of Nursing in London gave the oration at The New South Wales College of Nursing (1954, p. 284). She addressed the topic "Nursing care and nursing education" and her concerns about nursing education were as follows:

> Good nursing care arises from good nursing education. The true aim of nursing education is a better nursing service. The existing apprenticeship system wherein the so-called student is an employee of the hospital was at one time effective in the staffing of hospitals. It has turned out many fine nurses. But apprenticeship training under today's conditions, and which consists simply of a variety of experiences without adequate instruction, co-ordination and supervision is failing even to get all the work of the hospital done.

Here is another statement from a nurse who emphasised the importance of educating nurses and pointing out the problems in the apprenticeship system. For her 'good nursing care' and 'good nursing education' were interconnected. Carter (1956) wrote about the typical student nurse employee in the United Kingdom in an article in *International Nursing Review*:

> The use of the student nurse employee to do the work of the hospital has created an economic problem of the first magnitude. In the United Kingdom, it was shown in the inquiry made by the Nuffield foundation in 1953-54 that 75 per cent.[sic] of the nursing is done by nurses in training.

Furthermore, Carter (1956, p. 15) saw a downside to using student nurses as employees:

> What is worse, this usage has been rationalized, until a girl wishing to nurse, whatever her capacity, intelligence and education, is compelled to undergo a lengthy period of training based on tradition and the desire for labour and not on any scientific determination of the time necessary for adequate preparation for the responsibilities to be assumed. Nor have the hospital staff known how to make the best use of their qualified nurses. All too often staff nurses and head nurses have been given positions for which their apprenticeship training has not really fitted them.

Failure of the apprenticeship system in nursing was also caused by the shortage of qualified nurses in hospitals. Bed numbers had been rising rapidly, medical technology increased the patients' hospitalization and the amount of care needs for patients had increased. There was a shortage of nurses who were skilled in terms of management and control of nursing care and also a shortage of supervisors for the students. The apprenticeship model worked well for small numbers in small workshops.[68]

Voicing the need for change

Burbidge (1954, p. 285) also stated in her oration at The New South Wales College of Nursing: "Apprenticeship is only successful where the master appreciates his responsibilities for the teaching of his trade and, given the opportunity, is both willing and competent to fulfil them". Negative voices were getting louder in Australia. In 1955, an article 'The apprenticeship system of training – Is nursing in Australia handicapped through lack of university nursing school?' was published in *The Lamp*. The article was based on a debate which took place in Melbourne at the Australian Nursing Congress, arranged by the College of Nursing Australia. The audience consisted of nurses, nurse educators and nurse administrators and others who had links to the nursing profession.

In the debate, the three panellists questioned the apprenticeship system. Miss

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[68] In South Australia, the variety in size of hospitals was classified from A to C. A class A hospital had the highest number of beds compared to the class C training school. Consequently, the nurse trainee at the class C served two years after completing the two year class C training school. This classification continued until the 1980s. This system meant that nursing students in small hospitals would get less experience than students at bigger hospitals. Hence, the emphasis of training was on how much experience nursing students received during their training. There is an assumption that more experience is good for students, whether supported or not.

Peterson, the first speaker in the debate listed 25 reasons why nursing in Australia was handicapped through the lack of university nursing schools. These reasons are listed in the table as below (Peterson 1955, pp. 16-7).

Table 3: Based on the article 'The apprenticeship system of training' (*The Lamp* 1955, June-July, pp. 16).

1. Present nursing service is inadequate to meet the growing demand.
2. Insufficient qualified nurses available.
3. Hospitals understaffed.
4. Wards overcrowded.
5. Hospital beds closed.
6. High wastage during training (50%?)
7. Trained nurses leaving the profession.
8. Recruitment fails to meet the demand as other equally satisfying fields of service become available.
9. Present system of nurse training does not satisfy the "University minded" student.
10. Our present system of preparation fails to provide the same education opportunities, job satisfaction, or professional status of other professions.
11. Nurse leaders are handicapped by the present preparation, restricted to nursing subjects, which does not give the insight necessary to cope with the increasing problems.
12. The only training system known to nurse leaders is the "apprenticeship system" and they fail to realise that this is now outmoded.
13. The demand for nursing service by the hospital does not allow for education of the nurse, nor can the hospital function as a school under the present system.
14. Nurses are frustrated because they cannot give the quality of care necessary to each patient, and likely to provide the nurse with feelings of satisfaction.
15. The field of nursing must expand at the same rate as the Medical Services expand.
16. Increasing cost of maintaining hospitals brings added pressure, so that the apprenticeship system is seen as a cheap source of labour and a relatively stable source of service which is not always confined to nursing duties.
17. The present day nurse requires skills different from those used by her predecessors.
18. Nurse leaders need a broad and liberal preparation at University level if they are to be able to solve nursing problems and maintain a progressive service.
19. Nursing research is essential if suitable solutions are to be found quickly, and nurses must be trained in Research method.
20. Every effort must be made to improve the standard and efficiency of nursing care and by so doing raise the Australian Standard of Health.
21. Nurse leaders must be able to produce logical, reasoned and objective arguments free from bias.
22. Nurse leaders must understand the work of other groups participating in the Health Service.

> 23. Nurse leaders must be understood by the leaders of these groups.
> 24. Nurse leaders need to be given the professional status held by many other groups participating in the Health Service and only provided by a University education.
> 25. If nurse leaders are unable to guide the profession so that an efficient and progressive standard of service is given, the control may pass into other hands.

Peterson refers to the economic aspects of the nursing training system. For example, number 16 in Table 3 concerns the relationship between hospitals costs and nursing workforce. In other articles being published by nursing journals during this period, there were hardly any discussions on the economic aspects of nursing education by nurses, although the wastage of trained nurses was discussed frequently. Nurses were not involved in the discussions on the budget for the nurse workforce. It was not part of the nurses' role. The nurses did not emphasise the need for nursing educational system change through an analysis and critiquing of the costs and benefits of each system.[69]

Following these claims, Paige who participated in the discussion pointed out, "There is an interesting demand at international and national levels for nurses with a broader education than is provided in Australia at present". She claimed that:

> Nursing in Australia is facing a crisis and a satisfactory solution must be found quickly to prevent further deterioration with harmful effects to the community. In our opinion this condition is caused by a breakdown in the apprenticeship system of training, and this is no longer effective or adequate. The solution found must be applicable to all problems confronting nursing in the Commonwealth, and capable of future adjustment (Peterson 1955, p. 20).

The call for changes to the nursing apprenticeship system arose at the nursing profession organisational level. She used the term 'our opinion', which implies the opinion of the New South Wales Nursing Association. Nursing in Australia had started to question. By the 1960s, the number of articles discussing nursing training as 'nursing education' had increased dramatically. Moreover, the articles' titles and key words such as 'nursing education', 'curriculum', 'learning' were frequently

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[69] However, it took twenty years to achieve the nursing tertiary education in 1970s. The major issue regarding nursing in tertiary education was the funding of nursing education. Financial costs are discussed in Chapter 3, p. 75.

found in the nursing journals in the 1950s and 1960s.

From voice to action

The nursing professional organisations were also influential in suggesting a transition to a new educational system. The Tutor Sister section within the Australian Nursing Federation was influential in forming a new curriculum.[70] Durdin reflected on the early days of the curriculum workshop at the RANF in the 1960s. Tutors and Sisters in hospitals were willing to construct the new curriculum and became excited about this (Durdin 2006, pers. comm., 17 November). Verbalising improvements to the nursing education system was the key. Having opinions about independent institutions in the education system was the first step toward establishing a way to deal with uncertainty about nursing education. However, it took another twenty years to form an independent nursing school (not situated in the hospital) in South Australia after frequent inquiries and increasing lobbying by nurses (see details in Chapter 3, pp. 75-79).

Curry (1977, p. 5) is one of the authors who argued the necessity of nursing education in tertiary education. He stated the importance of nursing education accommodating own theory, in his case utilising the nursing process in curriculum (Curry 1977, p. 5-7):

> The nursing process concept has also been widely used an argument for the need for tertiary education for our nursing staff. This concept involves the ability of the nurse to assess, identify problems, implement plans of action and to evaluate this implementation. It is thought that these skills are to be learned in the environment of a tertiary institution…

Curry believed that the nursing process could not be successfully learned in a task-oriented learning environment. Curry (1977) reasoned that the nursing process is based on a patient-oriented relationship, between nurses and patients. In this sense, Curry's nursing process agrees with Orlando's nursing process, although he uses the steps used in Yura and Walsh's nursing process. Curry's emphasis in learning

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[70] The former professional body was called the Royal Australian Nursing Federation (RANF) and Australian Trained Nurses' Association (ATNA).

nursing process is based on his belief that nursing education in tertiary sector will enable nursing students to cultivate the ability to incorporate the nursing process in their thinking and practice.

In summary, nursing cannot be taught just in practice or just as theory, but learned, aplied and revised in practice as well. The emergence of this argument implies that it was accepted that nursing was recognised as a teachable discipline. There were new debates about how much nursing practice and theory should be taught and in what proportion, because nursing consists of both practice and theory.[71]

The case of South Australia

The curriculum in training schools in South Australia was not contested until the late 1960s when the 1000 hours curriculum was developed (implemented in 1970). The change to the nursing training system did not change close relationship between the nursing training system and the Nurses Board. A letter from the Nurses Board written by Bernard Nicholson dated November 1969 and forwarded to The Honourable The Chief Secretary (Nurses Board of South Australia 1969) stated:

> The value of the current programmes in South Australia has been limited in the extreme, as they are traditionally apprentice-type and planned in relation to specific clinical techniques, rather than to fostering the overall clinical skills of the Nurse and Nurse Aide, by meeting the objectives of the curricula…In August, 1966, the Nurses Board of South Australia therefore agreed that the curricula of training for nurses and Nurse Aides, together with the number of hours instruction required, should be reviewed.

The state government's argument was submitted and it suggested that nursing skills within the traditional training system were unbalanced. The letter also claimed that the training system was not consistent with the objectives in the curricula. Behind this recommendation to the government, there was a plan by the Tutor Sisters Section of the RANF to change the Nurses Act. The recommendations from this Section conveyed to the Nurses Board, were to increase the educational entry

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[71] These new questions and debates continue to re-surface. The problems centred around the overriding importance of clinical experience or learning experience.

requirements of those selected to begin their nursing training. After discussions between the Board and the RANF, the new curriculum was finally implemented – the 1000-hours curriculum.[72] Following legislative changes in 1970, the nursing training school at the Royal Adelaide Hospital made some changes. It was the advantageous for nurse students in terms of separating training from practice and studying at school. Durdin (1999, p. 173) explained:

> Before 1970 student nurses attended all lectures in their off-duty time, apart from the time they spent in the PTS. The adoption of the 1000-hours curriculum in 1970 required hospitals employing student nurses to release them for formal instruction at intervals throughout their training. This arrangement of instruction was known as the study block system. The RAH School of Nursing anticipated its development by increasing the number of student nurses and tutors.

The 'block' system was linked to a particular way of teaching nursing based on medical specialties such as surgical nursing, ophthalmic and orthopaedic nursing and so on. This system also implies that the nursing knowledge system was underpinned by medical knowledge.[73] In later years, the way to teach nursing shifted from the nursing process as a method of problem-solving in medical specialities to clinical reasoning with individual patients (will be discussed in Chapter 7). In this latter approach the gap between theory and practice remained, but what constitutes 'theory' had changed.

Difficulties in the relationship between hospital and training school

Durdin (1991) described the RAH nursing school as residing in the hospital, but the separation of the theory component and practice component in nursing education brought about changes in terms of nursing as an independent discipline. This produced contradictions. The belief that learning theory needed to be 'close' to the clinical practice area and yet separated became controversial and continues to this

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[72] The Royal Australian Nursing Federation was an important influence on the education of nurses. There are several recommendations made by RANF regarding nursing education. For example, in 1962 the recommendation for the Nurses Act that increased the membership of nurses on the Nurses Board. In 1967, the education standard for entry to nursing training was raised to completion of third year of secondary schooling (Durdin, 2007, pers.comm., 25 June).

[73] Nursing students were expected to practice in a particular medical specialty such as nursing for orthopaedic patients, cardiovascular patients, etc.

day. It is questionable whether the geographical distance made any difference to the distance between theory and practice.[74]

The new curriculum attempted to separate theory and practice, but the school was still part of the hospital in terms of administration. Durdin (1991, p. 193) explained attempts to change this relationship between the hospital and the nursing school as follows:

> In 1973 an officer appointed to report on nurse education at the Royal Adelaide Hospital recommended the separation of the school of nursing from any links with the hospital service and administration. As a middle-level training establishment the separately funded school would become the responsibility of the Department of Further Education. The Director of Nursing and nurse educators at the hospital did not support the proposal, perceiving the Department of Further Education as inappropriate for general nurse education, and no further action was taken.

Although this proposal would have established trainee nurses as students, it was not welcomed probably for two reasons: one it would mean less control over trainees who were also employers; and more importantly it went against the *Goals in Nursing Education Plan* (Royal Australian Nursing Federation et al. 1976) to shift nursing education to the higher education sector. The Department of Further Education had oversight of the trade based education sector (TAFE) and this was not seen as suitable to the professional goals of nurses. Hence, it led to nursing opposition from the Director of Nursing and Educators. The strong connection between the hospital and nursing training school remained until 1993 when the last students graduated. Although the RAH nursing school did not accept administrative changes into the education sector and remained a training school with a hospital administrative structure, the movement toward nursing education changes in terms of establishing the nursing school as part of educational administration was influential.

The relationship between medical doctors and nurses

The first issue was the nurse 'training' system that had been based on the

[74] There is a research-based reference demonstrating that the college educated graduate nurses were different from the hospital-based training course graduates in terms of independent thinking, questioning ability etc. (Pickhaver, Young & Goldsworthy 1985).

apprenticeship model as I have discussed. The second issue related to concern the relationship between medical doctors and nurses. This can be also characterised as vagueness about the role of nurses. McAllister (1950, p. 13) was a minister of religion and claimed that there was a crisis in the nursing profession.[75] He believed it necessary to reform nursing training in order to improve the nursing profession at the time. He insisted on improvements in the nursing profession in his paper. McAllister (1950) criticised the training system and questioned who would be responsible for nurse training to make the changes work. He described the physicians' claims as follows:

> Some physicians say that they can take any young girl and teach her to be a good nurse for their patients in a matter of days. This may be true, and nursing educators should study the significance of such statements. But the truth will depend upon what sort of patient the physicians have and what they expect the nurse to do for them.

This passage appears at first glance to claim that the nurse is essentially the doctors' handmaiden and that the nurses depended on the physician's work. He appears to claim that nurses could not afford to think about themselves in their own terms but in their relevance to medicine instead. In addition, the teacher of nurses was the medical doctor who was specialised in medical knowledge and had the skills, so what was taught was a form of medical knowledge and skills, not nursing. However, he goes on to state that good professional nurses have an 'educated heart' and these attitudes cannot be taught by medical doctors. The argument was based on role function and strict role differentiation, and he states the need for nursing education to be done by nurses. He also asserts the value of university education for nurses.

Thus, the relationship between medical doctors and nurses was coloured by the role of nurses being defined largely by medical doctors.[76] Moreover, in terms of decision-making action, the nurses could not decide on a patients' care when that article was written, but McAllister implies that this could be the role of the educated nurse (1950,

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[75] McAllister (1950, p. 13) wrote: "Compared with medicine, modern nursing is an infant, scarcely a century old." His article originally appeared in the *American Journal of Nursing* and was later reproduced in *The Lamp.*

[76] See the arguments in Chapter 2. The curriculum for nursing training was legislated by the committee, which consisted mostly of medical doctors.

p. 4):

> A nurse needs maturity. She is not going to be the nurse patients
> need until she achieves the development which comes with time
> and experience. Secondly, the nurse needs considerable
> instruction, not because she is a technician, but because to be a
> good nurse she must be more than a faultless tool. There are
> crises when only her educated judgement will save a patient
> from injury or even from death.[77]

McAllister (1950) claims that nurses need to be taught not only technical skills, but also to be thoughtful, in terms of providing safe nursing care. To enable this, nursing should be taught in the colleges (1950, p.13). In the hospital-based nursing training with training by doctors, autonomous nurses were not cultivated.

The motivation to change nursing training and to introduce education for nursing came about largely through a failure of the apprenticeship system to recruit, educate nurses for their expanded role and retain nurses. Nurses argued for nursing education at the tertiary level to improve nurses' knowledge and skills. Hence in regard to what students learnt at nursing school, the curriculum became more complex. It had not only an industrial purpose, but also one in which nursing was a discipline, implying distinct nursing knowledge.

Curriculum as the 'rhetorical vehicle'

The term curriculum is derived from the Latin term *'currere'*, which means running a course. From primary schools to universities, all schools have a curriculum. The concept of curriculum has changed from listing content to including philosophy and pedagogical approach. Indeed, the professionalisation of teaching is similar to nursing in terms of what governs and regulates teaching practices. The process of nursing education was shaped by theoretical perspectives on education and buttressed by growing scientific understanding about learning and teaching. Grundy (1987, p. 5) explained:

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[77] The context of McAllister's article is not known. It was originally published in the American Nursing Journal and then reprinted in *The Lamp*.

> Curriculum is often written and spoken about in an idealistic sense as if there is a perfect 'idea' (*edios*) of curriculum of which all individual curricula are more or less imperfect imitations…Curriculum, however, is not a concept; it is a way of organizing a set of human educational practices. I shall call these two ways of engaging in consideration of curriculum matters a conceptual and a cultural approach.

As Grundy (1987) states, a curriculum is a set of ideas and the purpose of the curriculum is to create a learning framework for students and how they learn based on the foundations of a particular discipline. It contains ideologies, ways of thinking about nursing, and technological devices, thinking tools for nursing, which shape the curriculum. A curriculum document is aspirational and it does not necessarily achieve what it aims to achieve but indicates where nursing sees itself going. Therefore, what is taught and learned may of course be different to what is stated in the curriculum document. This is how curriculum becomes merely 'rhetorical'.

The idea of curriculum was also influenced by psychological developments in student learning. Approaches to learning became explicit in curricula whereas before they had been implicit. This is a shift in emphasis from what students will learn (for example, the NBSA curriculum guideline in the 1950s listed contents in the form of a syllabus) to how students will learn with an emphasis on independent learning and specific cognitive skills (for example, Flinders University's curriculum development from 1992 to 2007, which will be analysed in later chapters).

The term 'rhetoric' implies that the word is disconnected from their context and used to different argument. Hartley (1994, pp. 266-7) explains that rhetoric requires us:

> to attend the sign system itself (whether verbal or visual), and to concentrate on the devices and strategies that operate in **texts** themselves - it offers a well-established and elaborate set of terms and classifications we can use to see how sense is made, not by reference to imponderables like **authorial** intentions or 'truth to life' but by reference to actual **discourses**.

The meaning of curriculum differs depending on the situation where it is used. For example, 'curriculum' in nursing has been used since the 1950s in various journal articles. The assumptions behind the appearance of curriculum in the 1950s speak of providing the framework for nursing courses, which was still hospital-based nursing

education. In this context, the curriculum referred to the program for nursing training. The sign system (of curriculum) worked to construct the context of them, however the nursing students as learners and the role of nurse educators was not included. Nursing training was still based on the apprenticeship model in the hospitals and the needs of industry and a secure workforce. Although the term 'curriculum' was used, the meaning of term and the actual discourses of nursing training and nursing professional education were disconnected. Thus, the assumptions and implications of the term are crucial to understanding the employment of 'rhetoric' in the curriculum. Billig (1987, p. 91) puts it this way:

> …to understand the meaning of a sentence or whole discourse in an argumentative context, one should not examine merely the words within that discourse or the image in the speaker's mind at the moment of utterance. One should also consider the positions which are being criticized, or against which a justification is being mounted. Without knowing these counter-positions, the argumentative meaning will be lost.

Indeed, it is not enough to see the term used in only one way. What makes the words meaningful are the elements of discourses that have been argued for. So what does nursing curriculum really mean? Nursing curriculum influences and is influenced by society to create the 'ideal' role of nurses in a particular time and place. What pushes the nursing curriculum is nurses' ambitions (described in Chapters 2 and 3). In addition, society influences the nursing curriculum in terms of economics and the prevailing view of the professional, for example leading to a 'scientific' nursing process which was described in Chapter 4. Thus, 'pushing' and being 'pushed' constitutes nursing as a professional discipline; it is not merely a debate over what constitutes nursing but how and where nurses should be educated. Nursing curriculum also constitutes the hope and aspirations of nurses to whom the changes in nursing apply. In this case it becomes a political device to achieve nursing's goals.

Curriculum as constituting knowledge, teaching practices, and subjectivities of teachers and learners

In this section, I show how redefining the curriculum established nursing as a discipline separate from the apprenticeship system. Curriculum can be considered

from a number of different perspectives each of which will influence teaching and learning outcomes in different ways. First, I will look at how the curriculum has been considered by different writers to show how this shaped much of the debate about nursing curriculum. I will show how the different curricula operated in terms of having different purposes. A curriculum may be defined in terms of a body of knowledge, a product, a process and a praxis (Ross 2000).

Curriculum as a body of knowledge

This type of curriculum highlights the body of knowledge to be transmitted (Ross 2000, p. 101). The curriculum tends to limit the body of knowledge, because the contents and what is taught is already included in the curriculum. The curriculum assumes a more or less finite body of knowledge which can be taught to prepare a nurse for practice. If the curriculum is 100 % of a knowledge box, there are no expectations of outcome more than 100 % from the box. What is packed in the box is limited and decided from the outset. This is also known as the syllabus form of curriculum.

Ross (2000, p. 101) describes this type of curriculum as 'content-driven' in terms of the curriculum informing the delivery of knowledge. However, Ross (2000) also claims that views about the curriculum vary between authors. For example, Goodson (1997) sees content-driven curriculum as basically academic in nature while Lawton et al. (1978) see it as knowledge-centred. Although Lawton et al. (1978) did not mention the relationship between the curriculum and academic study as Goodson did, his view of curriculum is "concerned with the transmission of knowledge from one generation to the next" implying that what needs to be know is known.

From the perspective of nursing education, student learning focuses on a pre-established body of knowledge about nursing. This curriculum can be described as traditional where subjects are important, for example the 1950s curriculum. The Acts (see Appendix 2) describe the subjects for nurses' training and examination and these are a 'check-list' type of description. In anatomy and physiology for example the items consist of bones, glands and organs, etc. Durdin (1991) explained the block system of nursing education as curriculum consisting of a body of knowledge. The

1960s curriculum guideline from the Nurses Board of South Australia also describes items to be included in the nursing curriculum (see Appendix 7). The curriculum guideline is based on subjects such as physics, chemistry, nutrition and psychology, etc. that imply the need to gain a broad knowledge underpinning practical nursing matters. In this sense how the students were expected to behave as nurses was made explicit. 'Uncertainty' is dealt with by being prescriptive about knowledge and the assumption is that all nurses need to know is already known. In this environment, all students will develop knowledge from class room interactions but more as apprentices who are to be supervised. It was teachers' responsibility to control how much and what prescribed knowledge the students should learn.

Curriculum as a product

Compared to the content-based curriculum, curriculum as product focuses on the goals of learning. The curriculum is associated with the development of competency so that it can also be described as a 'competency focused curriculum', in which the competencies are often defined in a narrow behavioural form. The objectives are set out as "The students will be able to…" expressions, and within this curriculum framework the educators promoted the idea of students changing their knowledge skills and attitudes to achieve new objectives.

Ross (2000, p. 98) described this classification as an 'objective-driven curriculum'. Lawton et al. (1978) described it as a society-centred curriculum. The students in this curriculum framework are expected to achieve certain goals. In this sense of producing outcomes, Tyler's (1949) curriculum can be categorised in this way. Bevis (1989) referred to Tyler regarding the change in nursing curriculum after the Second World War:

> This model makes neat, circular package that brings with identifying behaviors [sic] and ends with evaluating to see whether those behaviours that have been identified have been met. Since it is behaviorist, it holds that all learning is manifested in changes in behavior. If behavior has not changed, learning has not taken place (Bevis 1989, p. 24).

The Tyler curriculum model contributed to nursing development with its concept of evaluation-oriented, measurable behavioural objectives. Within this curriculum style, the learners have clear objectives and are evaluated. The curriculum was used to

promote a college-based nursing education system in the USA (Bevis 1989, p. 8). In nursing education in Australia, the product-focused curriculum was not as strong as in the USA, but Condon (2007, pers. comm., on 13 February) recalled the experience of teaching the behavioural model as part of the requirements for the Diploma of Teaching (between the 1970s and 1980s) and Bachelor of Nursing (nurse education) at Sturt Campus.[78]

During the 1970s-1980s Sturt CAE (now Flinders University) offered a product-based curriculum, in which requirements to be a nurse were more precisely described. The description of students' expectations in college education were in the first curriculum booklet published by Sturt College of Advanced Education (the details of which will be analysed in Chapters 6 and 7). The 1970s curriculum did not include competencies as graduate attributes or have an overriding emphasis of teachers' beliefs. The ideology of nursing was embedded into the curriculum with the hope it would be successful in college-based nursing education. Compared to this curriculum, the 1980s curriculum described the curriculum in terms of a competency-based standards framework. The emphasis on curriculum as a product was stronger than ever before due to the economic rationalist views in the higher education sector, but how it would be measured became controversial.[79]

College-based nursing education in the 1970s attempted to secure the students' status as learners and to establish nursing as a discipline in the tertiary sector. The emphasis was learning and to 'educate', not to 'train'. In the sense of 'educate', this meant seeing the students as learners and focussing on cognitive skills, not only on technical skills. Learning requires time for change and a process to make change possible. The 1970s curriculum saw students as learners and accommodated curriculum as creating a product. 'Uncertainty' that is internal to the nursing profession was dealt with by prescribing what students were to achieve under certain

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[78] See also Perry and Moss (1989), of 'Generating alternatives in nursing: turning curriculum into a living process' in *The Australian Journal of Advanced Nursing*. They critique the traditional type of objective-oriented curriculum and cited one university's curriculum development as a transformative one, which "incorporate[s] a dialogue on education and nursing traditions and on the qualitative, lived experiences of students and graduates" (1989, p. 40).

[79] The discourses will be further discussed in Chapter 7.

behavioural objectives and competencies. In this sense responsibility for student learning was shared but still mostly owned by the teachers.

Critique of Tyler's curriculum

Tyler's curriculum influenced the nursing curriculum by providing a new perspective. In the USA, as a part of 'scientific' approach to education, Tyler's curriculum model was accepted by the nursing schools.[80] However, weaknesses in Tyler's model were pointed out. Although it took on board learners' perspectives, it tended to focus only on task and behavioural changes. In the behavioural curriculum, learning is planned but does not foster an attitude in nursing professionals to work autonomously. The expected outcomes students are learning based on the completion of known tasks. Certain input (curriculum as a body of knowledge) and expected outcome (curriculum as a product) were central expectations in this curriculum. The learners' perspectives and knowing how to learn, dealing with situations not previously encountered setting and problem are missing in this type of curriculum. Problems with this type of education were outlined by Schön (1987) and Benner (1984).[81] Bevis and Watson (1989, p. 30) also commented on the limitations of a behavioural curriculum:

> …for certain aspect of baccalaureate education and most of master's and doctoral education, it is too limiting. One of the main problems of the model is the requirement that behavioural objectives be devised for all planned learning. Another is rigidity and narrowness of the model's conceptualization of behavioural objectives.

The limited objectives and inability to improve on what was planned were emphasised by Bevis and Watson. As previously mentioned, the transition to the tertiary education sector promoted nursing as an academic discipline. The adoption of a behavioural curriculum reflected similar approaches in other academic

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[80] Bevis explains the curriculum argument in the U.S. and describes how behaviourism spread Dewey's idea Bevis and Watson (1989, p. 26).

[81] Schön wrote *Educating the reflective practitioner* (1987) and explained the importance of coaching the students to encourage bridging their experience with reflection on their growing professionality. Benner (1984) investigated how nurses' professionality deepened with their experience and categorised the nurses from novice to expert level. Schön and Benner greatly influenced competency development in Australia. Both authors see the students (or nurses) as 'learners'.

disciplines in the USA at the time, such as education, by which nursing was influenced. Australia's different school and hospital systems were not as strongly influenced by behaviourism as were USA nursing schools. However, the curriculum discourses do clearly influence the thinking about nursing education in Australia and also reflects educators' thoughts and attitudes concerning nursing education.

Curriculum as a process

In the curriculum as process perspective, the focus is on the processes of knowing and learning. In the content curriculum, the 'learning' of students was not considered other than as evidenced in reproduction of knowledge. Similarly, the goals of the product this curriculum were to achieve and produce outcomes. When the focus shifted to curriculum as process, it became more student-centred. Ross (2000, p. 136) describes the features of this curriculum as a child-centred and process-based operation:

> …the role of the teacher is to enable learning, not to transit [sic] knowledge; and the learning process should be organized for individuals, not class-sized groups…The teacher, through a carefully engineered exploitation of experiences of everyday life, highly structured, orderly and disciplined regime.

Ross (2000) highlights the different perspectives inherent in the curricula in terms of their ownership. He says that learning process should be prepared for the individual and not for the class as a group, generateing individual ownership of the learning process.

The self-directed and student-centred focus of this curriculum also provides flexibility in learning. The interaction of the teachers and students is greater than the other curriculum perspectives, which tend to be teacher dominated. In this sense, the process curriculum has more space for learners to question things and the knowledge and outcomes of learning are less focused on content.[82] The focus is on application of the method to achieve educational outcomes in learning. In other words, nursing students learn through the learning process 'leaning how to learn' how to face

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[82] This curriculum perspective is described by Smith (1996, 2000): the curriculum is "an active process and links with the practical form of reasoning set out by Aristotle". Reasoning is the form of understanding of knowledge.

uncertainty. Uncertainty in nursing is dealt with by teaching thinking processes and the responsibility of learning is shared with students who are seen as developing as autonomous learners.

As described previously the 1970s tertiary curriculum situated learning as the central activity. In professional education the focus is on 'learning how to learn' and the method of learning such as problem-based learning is commonly used and emphasised. For example, the 1987 curriculum stated about learning (South Australian College of Advanced Education 1987, p. 13):

> Learning approaches and teaching-learning strategies adopted
> are properly left to the course planning groups/staff teaching in
> the course…These include:
>
> -experiential learning
>   -learning principles of care (rather than procedures)
>   -the sharing of learning with other student groups
>   -choice of sequencing (by student)
>   -the notion of learning how to learn
>   -students taking a degree of responsibility for their own
>   learning

In this description, the educators' strategies are clearly stated and the students' own learning responsibility is mentioned as being shared with the teachers (who still take responsibility for content and method). Recognition of students as autonomous learners is essential to the curriculum process. This curriculum will be further explored through the learners' and educators' positioning in later chapters.

Curriculum as a praxis

This type of curriculum also sees the extension of 'curriculum as a process' and responds to students' emerging learning needs. The term 'praxis' "is the fundamental concept in Freire's work and is fundamental to the emancipatory cognitive interest" (Grundy 1987, p. 104). The praxis model of curriculum is based on the idea of interaction between action and reflection. The action of praxis encourages personal development. Smith (1996, 2000) also describes:

> Curriculum as praxis is, in many aspects, development of the process model. While the process model is driven by general principles and places an emphasis on judgement and meaning making, it does not make explicit statements about the interests it serves.

Smith believes that practice and theory interact and the process is situated centrally in this type of curriculum. This approach to curriculum enables learners to recognise their own learning process. The assumptions here are that students are expected to learn autonomously, supported by educators, by using reflection to understand their learning achievements and learning needs. Educators promote students' autonomous learning by stimulating students' learning in an effective way rather than by simply handing over knowledge. Hence, students' learning is open and based on individual learning needs.

Grundy (1987, p. 102) also explained that curriculum as praxis is a student-centred approach and its ideology is based on learners' autonomy, by closing the gap between what students do and what students learn. This curriculum is useful for nursing in that the discipline is heavily weighted in favour of practice and making sense of practice, and merging theory with practice. However, this curriculum implies that if students' learning does not occur, there will be no learning at all. In other words, 'occurrence of learning' depends on the students themselves. The teachers are expected to work effectively to help students 'learn how to learn' and to stimulate their learning. Teachers need to know the ability of students' to learn in-depth. Uncertainty is dealt with by ensuring students know how to learn and how to decide what to learn. The assumption is that their learning is based on autonomy and personal responsibility.

Various perspectives about the curriculum show how its meaning shifted in terms of the users – teachers and students. The implications in these curricula are different and these contrasts make the curriculum a vehicle for rhetoric. The changes in perspective on curriculum reflect changes in the role and status of the nurse. What changed and influenced nursing education curricula are not only socio-political circumstances and industrial issues, but also the influence of other disciplines on nursing. Tyler's curriculum model influenced the USA in the shift of at least some nursing education to the colleges and it became the model for credentialing nursing

education in tertiary education institutions. On the other hand, in Australia the shift to college-based nursing education happened later and was less influenced by behaviourism. In Chapters 6 and 7, the similarities between the specific curricula and charging beliefs about professionalisation over time will be discussed. The thinking tools of nursing, for example, nursing process as discussed in Chapter 4 also reflect different curriculum models and are discussed below.

The relationship between curriculum and thinking tools of nursing

In the 1960s, the process of nursing that Hall and Orlando focused on was the relationship between patients and nurses. For nursing students they explained that the foundation of nursing lay in the relationship between patients and nurses. 'The nursing process' was not emphasised either in nursing education or in nursing practice during the 1960s. The curriculum at this time was content-driven and stated what students had to learn.

Tracing back the nursing process movement to its beginning, it defined nursing based on the relationship between nurses and patients by investigating what is 'good nursing'.[83] It was a way at first to teach nursing at first with a patient-centred focus. However, the nursing curriculum gradually started to implement the nursing process after Yura and Walsh's nursing process was popularised in nursing practice (1973). Their nursing process, as a problem-solving method, influenced nursing practice. What were the reasons why nursing process as used in nursing practice were introduced into the curriculum of nursing education? The reasons were articulated in articles and textbooks published in the 1970s and 1980s and discussed below.[84] The nursing process suited the behavioural curriculum with a task-needs-oriented approach to the 'generic' patient. Here the problem-solving approach is situated in the realm of known solutions.

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[83] See Orlando's writing about 'process of nursing' in Chapter4. She investigated what good nursing is in practice and taught nursing students about the process of nursing.
[84] For example, see the article of Curry (1977).

The 'thinking tool' and its use in curriculum

The use of 'thinking tools' in nursing was initiated by the nursing process used in practice and education. This *episteme* involving the nursing process implies a description of differences between nursing theory and practice. It also implies that nursing knowledge development is to be considered as a part of achieving professional status.[85] Closing the gap between theory and practice was argued in some articles. Greaves (1984) published *Nurse Education and the Curriculum* and wrote (p. 22):

> Systematic approaches to detecting and analysing patients' nursing and health needs and establishing goals that are harmonious with their patterns of daily living and adapting and planning care accordingly are a new central element in nursing practice. This central element is usually identified as the process of nursing or the 'nursing process', and it embraces the specific skills of scientific method or problem-solving. This particular attempt at systematising nursing care is increasingly believed to be basic to all clinical nursing practice and is now receiving world-wide recognition.

This statement acknowledges the new importance of the nursing process to nursing practice. Greaves (1984) wrote that because the majority of nurses are using this process in nursing practice, so nursing students are also expected to learn the nursing process. The nursing schools' intention was to make sure students learned what was valid for their working lives and this was overseen by the Nurses Board's accreditation of curricula.[86]

Brown (1981) also reported on the implementation of a 'nursing process model' in a curriculum.[87] Brown (1981) explained that 'the nursing process model' consisted of three basic concepts describing the organizational structure of man; development, system and stress, around which the nursing curriculum is built. Brown (1981) also understands that nursing process is:

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[85] See Chapter 2, p. 48-9 for the explanation of one of requirements for a profession is to have 'a body of knowledge'.

[86] See the curriculum guide from NBSA for 1979 (Nurses Board of South Australia 1979). The guideline states that the nursing process will develop first level professionals who will be able to implement the nursing process in their practice.

[87] She was the former Assistant Professor of Nursing at Azusa Pacific College, California. In her article, she introduced the model (Nursing Process System Model) used at the college.

> utilized within the context of this theoretical framework or
> model. This view of man [sic] provides a framework in which to
> perform the various components of the process. Nursing process
> is a detailed problem-solving, scientific method for use in
> determining the need for nursing care and for providing this care.

Brown (1981) utilised a 'nursing process model', in which nursing process is a 'thinking tool' within a broader curriculum framework. Greaves (1984, p. 25) warns that the nursing process cannot solve all the issues in the conflict between the supremacy of either theory and practice, which had now became the overriding problem in the ongoing debate about how nursing status could be improved. He continues:

> A common assumption that the nursing process is the *theory* of
> nursing is both dangerous and, in the long run, non-productive as
> far as securing a unique body of knowledge is concerned (Greaves
> 1984, p. 25).[88]

Greaves (1984) supports the usefulness of implementing nursing process into the nursing curriculum but claims that care is required as to how it is introduced and that nursing process should not be relied on alone as the curriculum framework. He warns of the risk of losing a unique body of knowledge in nursing due to an unbalanced use of the nursing process in nursing education. He argues that nursing is not a linear process and cannot be generalised into one process. These debates are part of what creates the *episteme* of nursing process. The formation of discourses regarding the nursing process is based on the differences between the governance of the thinking tool and where it is used.

Moreover, there are two other possibilities to consider about the introduction of the nursing process into the curriculum. The first is the possibility that the concept of the nursing curriculum itself was changed to match the nursing process, which suits a product model. Another is that the problem-solving skill (i.e. thinking tool) was emphasised in nursing rationalism.[89]

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[88] See p. 102-4 for Yura and Walsh's argument that the nursing process predated the formation of theory.

[89] See 'technical rationality' discussion in Chapters 2, 3 and 4.

I have described the curriculum as a rhetorical vehicle and the container for the nursing ideas. As both sides; the container for accommodating nursing (curriculum) and the tools to fill the container (the thinking tools such as nursing process and problem solving skills, etc.) change in terms of the concept and meaning over time, nursing itself needed to adjust to these changes. Therefore, the concept of nursing changes its the meaning with disciplinary and social influences.

Parallel changes in curriculum meaning and the thinking tool

Curriculum as a rhetorical vehicle changes its approach and focus over time. Out of different opinions about curriculum design and implementation, discourses are produced. Greaves (1984, p. 25) puts the relationship between the nursing process and curriculum in the following way:

> The nursing process in its present form is a useful instrument which will help nurses rationalise and organise nursing care on patient-centred individual approaches. The theoretical and practical activities of nursing (nursing knowledge) should not be subordinated to one process approach, because the process is no more than an element of the whole. Nevertheless, it is a vital element and one that requires careful application and recognition within the overall scheme of things for nursing education.

With the expansion of the nursing process into nursing education and nursing practice in the 1980s, there were some authors that objected to nursing process. For example, Mitchell (1984) who was a doctor in the United Kingdom, writes sceptically about the nursing process in practice. He mentioned three problems concerning the nursing process. Firstly, he states that it is doubtful that the nursing process can develop the nurses' advocacy role.

Mitchell (1984, p. 217) writes, 'Clearly most nurses believe sincerely that the process could improve patient care, but I believe some nurses see it as a bid for independence from what they regard as medical domination'. He quotes the explanation of the medical doctor's authority and asks what would happen if nurses admit patients to hospitals. He seems to believe that nurses think that the nursing process will enable them to have the authority to make judgements like a medical doctor and this rise professional decision-making in nursing posed a challenge to doctors. Secondly,

Mitchell writes that the value of the process itself is doubtful and emphasises its use in the system stating, 'There can surely never be a nursing process if the patient rather than the system is to be paramount, so we must now begin to plan for "processes of nursing" rather than the "nursing process" (1984, p. 218). This statement implies that the focus of nursing shifted to the process itself at the service more of administrative systems than nursing care. His view also supports the view of Buss and Traynor (2005, p. 44), "…the process was locally 'fabricated'…It came to stand as an empty signifier for 'what nurses do' or for some idealized essence of nursing practice".

Finally, he states that there is a doubt regarding 'who needs to know what'. He mentions the difference between task-oriented nursing and patient-centred nursing and encourages the use of patient-centred nursing. However, he was afraid that the nursing process would simply become a task-oriented one. This critique mirrors Orlando's concept of 'automatic' process of nursing.[90] Mitchell (1984) adds, "Would it not be more sensible to build up a pyramid of knowledge so that new learners could concentrate on basic patient care rather than on checklists". It seems that he is afraid that nurses would make judgements based on automatic responses to patients regarding their nursing care. Mitchell's concern is about the influence of the relationship between nurses and doctors, in terms of their role, but also on the task-oriented nursing that relates to the 'bad' nurse as defined by Orlando.

Tierney (1984, p. 835) in response to Mitchell says that no threat to the relationship between nurses and doctors is posed by the nursing process. She states, however, "…we should not obscure discussion about the nursing process by concentrating on issues of professional territoriality". Due to the different role and focus of nurses and doctors, this process does not threaten doctors' role. Tierney also states, "Professor Mitchell seems to imply that there is a something new about describing nursing in relation to activities of living…there is something fundamentally misguided about doing so…" (1984, p. 835). She explains that nursing focuses on patients' activities of living, which are affected by their health and not the disease itself. The difference in nurses' and doctors', roles is marked in the nursing process. Finally, Tierney

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[90] See the discussion in Chapter 4.

(1984) states that the nursing process influenced the definition of nursing itself by clarifying the process of nursing care.

The speed at which the nursing process was implemented in nursing practice was not matched by the progress in nursing philosophy. The differences in implementation in the nursing process generated conflicts between nursing academics and nursing practitioners.[91] The nursing process was generally welcomed in the hospital setting due to its clarity of purpose. On the other hand, from the perspective of the nursing discipline and philosophy, there were disagreements with the nursing process. The discourses in the development of nursing knowledge had created this gap.

The notion of difference in texts

Difference in texts is described by Yura and Walsh (1973, 1983). They published the first edition of *The nursing process: assessing, planning, implementing, evaluating* in 1967 and revised it in 1973. The fourth edition was published in 1983. There are significant differences between the 1973 and 1983 editions. The 1983 edition contains frameworks of nursing that had not been included in the previous edition. They write (1983, p. 14):

> The profession of nursing is moving more deliberately to a science
> of nursing. Multiple disciplines and related science are being
> explored to assist in this endeavour. Philosophy of science is one
> of the sources that is relied on for guidance and direction…

The definition of nursing has been expanded to include other disciplines, which enabled the nursing discipline to become broader. It also seeks to treat the nursing metaparadigm' as a 'normal science'. The different theories referred to in their book reflected the expansion of theorising about nursing. In the 1973 second edition, Yura and Walsh write (p. 35), "Many different theories from various disciplines suggest a relationship to nursing process…general system theory, information theory, communication theory, decision theory, and theories of perception". These theories explain the methods in problem-solving as part of the nursing process, - not nursing philosophy. The emphasis was on the theory reeded to develop the process rather

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[91] See also the discussion in Chapter 4.

than on a theory to underpin the best way to care for patients. The fourth edition (1983) states:

> Although a major thrust in nursing today is the identification and use of theoretical/conceptual frameworks, the 1973 edition of The Nursing Process was a forerunner in the presentation of theories that guide and support nursing.

In this edition, why do they call 'the nursing process' a theory although they did not refer to 'nursing process theory'? Theorising nursing was more marked in the 1970s and 1980s and such theories were used in nursing curricula. Anderson (1979, p. 9) wrote in a publication of the National League for Nursing (NLN) in the U.S. that one of the essential elements of nursing curriculum is using a framework, which is clearly related to the philosophy of nursing (National League for Nursing 1989, p. 9). Anderson refers to the work of Torres and Yura's curriculum analysis and stated that the four concepts – man, health, society and nursing – are most frequently used in their 1975 publication (NLN, p.9). The curriculum components illustrate the external influence on nursing in the search for a theoretical framework, and their implementation in nursing education. Anderson (1979, p. 9) described the use of nursing skills and nursing process in the curriculum:

> Nursing process is often used as a horizontal theme which is introduced with all of its steps initially in the curriculum. The student continues to use nursing process in a variety of settings with increasing skill.

In this description, nursing process was not expressed as a theory but rather as a systematic tool providing a framework for applying knowledge and skills to improve current skills.[92] Furthermore Anderson (1979, p.9) states:

> Faculty may choose one of the models of nursing already in use or may decide to produce their own conceptual framework. Nursing models widely used are:…the choice and selection of the framework is described as consistent with the philosophy of the faculty of the particular nursing college…While there is

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[92] This comment supports Yoshizumi's comments about the relationship between nursing process and theory. Yoshizumi studied the nursing process at the Catholic University of America and she met Walsh there. She recalled: "Walsh used nursing process as nurses' steps of nursing practice. Use nursing process as the tool to climb the mountain (theory)" (Oishi 2006, p. 1018).

> interest on the part of some nursing theorists in using a single
> model or conceptual framework for nursing, it is unlikely that
> such conformity can be achieved nor is it desirable at this time.

Although Anderson wrote that implementing a framework into the curriculum depended on the faculty, Santora (1980) stated that confusion existed concerning the meaning of the conceptual framework and its role in the curriculum. She researched the use of conceptual frameworks in education courses for seven years and found that 41 programs out of 122 programmes identified as 'none' or 'ambiguous' regarding the use of conceptual frameworks. The reasons for these divided opinions were not clearly stated in the report but the following reasons could be considered. One is that the educators were afraid that nursing could be constrained within one framework. Another may oppose this and believe that nursing should be developed within one theoretical framework and another may not understand the relationship between conceptual frameworks and curriculum. Meleis (1997, p. 420) wrote:

> Although nursing theories have been used as frameworks for
> nursing curricula in undergraduate programs during the 1970s
> and 1980s, only limited number have included opportunities to
> discuss theoretical nursing and approaches to theory
> development (cited from Jacobs-Kramer and Huether 1988;
> Meleis and Price 1988).

Using a conceptual framework during this era created much confusion in nursing education and knowledge development. [93] It continued to be a problem with regard to the thinking tools. However, in this period Meleis (1997) wrote that nursing theorists no longer argued about why nurses needed theory; they accepted the need for a nursing theory and started to think about the elements required to establish nursing theory. Meleis (1997, p. 42) describes the goal of knowledge development as "…the establishment of the unique knowledge base of nursing. Discussions of what constituted theory and the identification of theory syntax seemed to be the means to achieve that goal". Her description is also based on a particular belief about what constitutes professionals (see Chapter 2).

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[93] The National League for Nursing in the U.S. required a theory-based curriculum for accreditation of the curriculum from the early 1970s onward.

During the decade from 1973 to 1983, philosophies of nursing were being explored and developed. As a result, nursing knowledge grew and influenced the nursing process. In 1982 Henderson, a nursing theoretician, wrote a critique of the nursing process as formulated by Yura and Walsh. Henderson (1982, p. 103) argues that, "it [nursing process] ignores the subjective or intuitive aspects of nursing. It also ignores the role of experience, logic and expert opinion as bases for nursing practice". Her argument is based on nursing being a holistic process which should not be seen only as a goal-directed activity. This was part of a broader critique during the 1980s.

Barnum (1987), another meta-theorist, supported Henderson (1982) and explained that in the nursing process, problem-solving processes tend to be goal focused: "The goal in problem solving is simply to remove the obstacle. The emphasis is on removing the impediment rather than on the specific way in which the removal is achieved" (1987, p. 32). Problem-solving in the nursing process had to take on a broader perspective. These arguments were made in the 1980s, especially by Benner (1988). The expert nurse does not necessarily use step-wise problem-solving processes, but as an expert is able to 'grasp meaning' in the situation (Johnson & Webb 1995).

As debate regarding the definition of nursing process deepened, how this concept became embedded into nursing education depended on the nursing educators. In this sense, the curriculum reflected the educators' thinking about nursing – how they understood nursing and how they would teach it in theory and practice. In this sense, curriculum proposes an idealised nursing education and provides a meeting between the nurse educators' nursing and educational beliefs and the expectation from the nursing practice setting. This is how the rhetoric of curriculum works. Consequently curriculum as an idealised form is always debated by nurse educators and influenced by the nurse educators' beliefs about the nursing profession and philosophy of nursing as a discipline.

Hidden curriculum within the nursing curriculum

The curriculum is described as a 'rhetoric vehicle' that projects the ideals in nursing education at any point in time. As time goes by, the nursing curriculum changes to reflect the contemporary perceptions of nursing and education. External and internal influences on nursing, change educators' thoughts about nursing. This can be observed through what educators historically wanted to teach students and what they expect of them. These thoughts are expressed as the philosophy of the school and objectives to be achieved.

These expectations concerning the nursing students are not only explicitly described in the curriculum, but also implicitly embedded in it. The nursing professional agenda with its moral imperatives also gives the curriculum meaning. As shown in Chapter 2, the professional agenda has been created through social expectations and nurses' willingness to utilise them. With these agendas and nursing curriculum, the students learn how a nurse behaves. The implicit messages in the curriculum are also defined as 'hidden curriculum'.

Hidden curriculum is defined as what students implicitly learn by experiencing the curriculum. What students learn is not all described explicitly in it. Students are expected to discover the implications of official curriculum in the hidden curriculum. In other words, the students may learn more from the hidden curriculum than the official curriculum. Therefore, teachers need to pay attention to coherence between these two curriculum types. Jenkins and Shipman (1976, p. 17) expressed this belief as follows:

> …But even more important is the unwritten yet potent set of influences exerted through the organisation of schools, churches, armed services and so on. This hidden curriculum consists of pressures arising from proximity with other learners, the formal and informal influence of teachers and the physical constraints of the organisation. The hidden curriculum includes all those pervasive values that one is expected to acquire by a process of institutional seepage: things like punctuality, good behaviour, tolerance of frustration, loyalty. These and other influences on the individual come from his or her involvement in an organisation with consistent assumptions as well as specific objectives, an elaborate set of expectations as well as a specific mode of working.

The students experience nursing practice and learn how to behave as professional nurses. For example, teaching nursing skills may include attention to safety and patient comfort skills. The hidden curriculum is based on how moral and ethical behaviour as a professional nurse is demonstrated by nurse educators as much as by what is taught explicitly or learned from a textbook. [94],[95] This construction of behaviour is demonstrated by the Panoptic influence on education (Foucault 1977). In other words, nursing is behaviourally modelled with certain forms of comportment, values and expertise as a nurse. This process is also seen as a process of socialisation - to be a nurse of a particular kind as society expects (see Chapter 3). Explicit and implicit elements of the curriculum will be included in an analysis of the curricula in South Australia's nursing educational institutions. This will show how the professional agenda has a moral imperative included in it.

Chapter summary

In this chapter, I explored how the nursing curriculum works as a rhetorical vehicle. It is constitutes of knowledge, teaching practices, subjectivities of teachers and learners. Therefore, curriculum changes with changes to any of these elements. For example, nursing as professional education was influenced by the concept of 'credentialing' and competency-based education in the 1990s.

Print (1993, p. 7) explained how the definition of curriculum changes according to the educators' perspectives and expressed, "Different people perceive a school's curriculum in different ways and sometimes in multiple ways depending upon the context in which the concept is used". The nursing concept (the thinking tools utilised to define this) used in curriculum to inter-related to the curriculum purposes. Thus in curriculum development, nursing process has shaped the role and function of the nurse over time. The introduction of nursing process (as the first explicit thinking

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[94] Nelson debates this point in *A Genealogy of care of the sick* (2000). She argues that nursing professionalisation has occurred through historical moral imperatives.

[95] Although the hospital etiquette was clearly written in the text book published in the 1960s, in the 1970s less etiquette was described explicitly. Etiquette has been replaced by 'professional dispositions'. For example, *A guide to clinical practice* (Flinders University School of Nursing and Midwifery 2007) requires the purchase of uniforms for clinical practice and explicitly names their styling.

tool of nursing) has had an enormous influence on the construction of nursing curricula and the definition of nursing. Curricula using the nursing thinking tool needed to balance the elements of nursing with others such as nursing ethos and philosophy and influences from other disciplines. Curriculum is an idealised programme for nursing/nurses and the meeting point of practice and theory. In other words, curriculum carries social expectations to maximise the role of nurses, which change over time and creating nursing curriculum as a rhetorical vehicle.

In the next chapter, curricula in South Australia since the 1950s will be analysed from the perspective of how the thinking tools of nursing were implemented in the curricula while the governance of curriculum changed.

CHAPTER 6 CURRICULUM OWNERSHIP

CURRICULUM DEVELOPMENT
BETWEEN 1950S AND EARLY 1980S

Introduction

The societal expectations of nursing as a profession and influences from within nursing produced dilemmas as to what form "professional education" would take. I have undertaken an historical description of this dilemma by exploring the *episteme,* 'nursing process', as this formed discourses informing what would constitute nursing education and practice. Different interpretations of what counted as curriculum also produced discourses on how nursing could be considered as a profession. Adaptation of the thinking tools of nursing was influenced by developments and progress in medical science which led to nurses using stethoscopes, syringes and sphygmanometers, and so on. The production of thinking tools provided new opportunities for nurses to deal with the uncertainties about its professional status and what counted as the nursing discipline.

The actual curricula in schools of nursing in South Australia, particularly at the Royal Adelaide Hospital Nursing School up to the 1960s and Flinders University including its antecedents, until 2007, will be used as a case study of the influences outlined in the previous chapters. [96] These curricula accommodated changing concepts of nursing. I discuss 'uncertainty' about nursing's warrants and practices as these curricula, show transformations and moves in nursing professionalisation as these operate in the actual curriculum and their developments over time.

The school at Flinders University had its origins in Sturt College of Advanced Education. The texts to be used as data are from Flinders University and its previous

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[96] The largest hospital and nurse training institution in the state.

institutions from 1973 to 2007.[97] Analysis of texts from these institutions will make dilemmas inherent in professional education more apparent. Also this process will show how uncertainties in the nursing profession derive from the ambiguous nature of nursing knowledge and definitions of nursing.[98] Moreover, this sense of ambiguity was driven by external societal influences such as expectations as to what counts as a profession and how this is used by society, other professions and nursing itself in its arguments for recognition and for the frameworks that form nurse education.[99]

Who governs the curriculum?

I examined historical curricula such as curriculum guidelines of the Nurses Board, and proposed curricula at nursing schools in the 1950s and categorised these under 'who is governing them?'. Modern nursing and nursing education – as Florence Nightingale's thoughts about nursing – explained nursing as a discipline taught at school, not by training; but who could decide what nurses needed to learn? Who could envisage nursing as a teachable discipline in a school? What is taught is greatly influenced by how nursing is defined at any given time and what the nurses' role is perceived to be. The context of what nursing students learn influences how these questions are answered at any time.

I have categorised the historical phases of curricula design and development as follows: 'Curriculum controlled by others'; 'A 'will to control' curriculum'; and 'First step to controlling curriculum'. This categorisation is based on who created the curriculum, in other words, who decided what and how to teach. In the following sections, I will show how these categories operate by assessing who controlled their design and development and also show how each curriculum informed nursing students' and teachers' attitudes about learning, under the differing circumstances each curriculum brought into being.

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[97] These were Sturt College of Advanced Education (SCAE, 1975) and South Australian College of Advanced Education (Sturt Campus, 1984-1990).

[98] The ambiguity was also argued as 'uncertainty' in Chapters 2 and 4 by describing the internal dimensions of the nursing profession.

[99] I described the characteristics of nursing professions in Chapter 2 and the role of nurses in Chapter 3.

Curriculum controlled by others

The curricula in the 1950s and 1960s were controlled and constructed by people other than nurses. In this period, the term 'curriculum' was not yet used, while 'training' and 'apprenticeship' were used to describe nurse education. What constitutes this phase of nurse education is where 'training' and 'apprenticeship' take place, and the practice role of nurses at that time. During this phase, nursing schools were based in hospitals and training and apprenticeship was controlled by non-nurses. The emphasis on producing a nurse was not necessarily to 'educate' nurses but to 'train' them for practice. Nurses were expected to be trained work and reside in the same location. Durdin describes training in this era as follows (1991, p. 187):

> In 1950 the process of learning to be a nurse was little different from 1921, when the regulations for training were drawn up by the Nurses Board. The emphasis was still on service rather than on education….Nurses still attended 49 'doctor's lectures' prescribed by the Nurses Board, with additional course in Invalid Cookery which could be taken before beginning training.

Although Durdin (1991) mentioned the regulations for training in 1921, which followed the Nurses Registration Act of 1920, the primary purpose of registration was not to regulate nursing training, but to manage the nursing workforce (see also described in Chapter 3, p. 58). Durdin's writing illustrates a disappointment in how little progress had been made in nurse education despite the Nurses Registration Act, with a continuing focus on 'training' for practice.

'Training to be a nurse'

Nurse training was provided in the hospital setting and the lectures were given by medical doctors. I could not locate a 1950s curriculum in South Australia, but control of nursing training was dominated by the Nurses Board, as Durdin described. What nurses needed for nursing training was largely decided by medical doctors who were acknowledged and recognised as the deciders of what was needed to service the hospital. In what counted as a training course program (as curriculum) in the 1950s for general nursing was governed by the Nurses Registration Act, 1920 and 1922 (Durdin 1999, p. 149). In the Nurses Registration Act (Nurses Registration Board

1926, p. 27), the programme for nursing training was described under the prescribed course of training for nurses:

> In order to become entitled to be registered as a nurse the trainee;
>
> (a) must pass through a course of training in the subjects mentioned in Schedule B [See the appendix 1] hereto in accordance with these regulations
> (b) must pass examinations [See the appendix 2 for the examples] in accordance with these regulations, in the following subjects of the said course:
> I. Anatomy and physiology
> II. General nursing, hygiene and public health, gynaecological nursing, and the nursing of diseases of organs of special sense
> III. Medical nursing
> IV. Surgical nursing and
> (c) must be proficient in the following subjects of the said course:
> I. Invalid cookery
> II. Housekeeping and hospital management

Each lecture's content are shown in more detail.[100] The number of lectures and the context of the lectures were already determined in the regulations. For example, in the section on general nursing, the distinction between doctor's work and nurse's work is discussed and the role of nurse is (p. 32):

> (a) Bedmaking, management of helpless patients.
> (b) Hygiene of the sick room. Ventilation, lighting, temperature
> (c) Baths (different kinds) sponging.
> (d) Cleaning and padding splints.
> (e) Prevention of infection.

These sets of tasks are explanatory and functional. The task lists for trainees does not indicate who cared for the 'patient' or 'client'. Moreover, 'hospital etiquette' was included in the regulations. The phase of description of the role of nurses and the function of nursing were expressed by the Nurses Registration Board as my analysis in 'the nurse defined by others' (see Chapter 3, p. 54). The syllabus outlined the content or matters that were needed to train nurses. As I discussed in Chapter 2 regarding the attitude of nurses, nurses were to behave morally, which characteristic

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[100] See Appendix 2.

was also shaped by religious imperatives.[101] In this sense nurses were not expected to utilise external influences such as new knowledge about the nursing training and the role of nurses and it is clear that the training program (or as we would call this now – a curriculum) could not be described as representing 'a body of nursing knowledge'. Moreover, the concept of 'educating' nursing students, as I explained in Chapter 5, is not present in these 1950s, 1960s Nurses Board documents.

Are they 'learning' to be a nurse?

To identify what was forming the context of nurses' learning in this phase I looked for terms that are common in educational discourses today. For instance, I did not find any use of the term 'learning' in curriculum documents for this period; the term 'training' was most frequent. The use of such a term implies that a trainee will follow instructions as these are provided by set procedures and set practices. Burbidge (1954, p. 285) described the training of nurses in the Second Oration of the New South Wales College of Nursing in 1954:

> Since the inception of apprenticeship training some minor improvements have been made in regard to nurse teaching…Training of nurses is really practice in obedience to routines and rules, to produce technical skills, to form behaviour patterns, all of which will function automatically.

In the use of the term 'automatically', there is no sense of developing the learning and cognitive skills of trainees. Methods to produce routinised responses to tasks were used. Burbidge's critique highlights how far nursing training was from a genuine apprenticeship system, as also described in Chapter 5 (see p. 126).

This rigid and inflexible system of training was based on the Nurses Acts, 1920 and 1922 (Nurses Registration Board 1926) (see Appendix 2) and endorsed by Nurses Registration Board. Diagram 14 on next page shows the relationship between training schools and the Nurses Registration Board in the 1950s. The Nurses Registration Board and the Registration Acts governed the context of training. What trainees gained from training was the procedural context of nursing, which was

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[101] See more detail description in Chapter 2, p. 33.

strictly defined by the Registration Acts as shown page 162. This form of learning occurred in the type of 'curriculum as knowledge' as I have outlined in Chapter 5. Indeed, nursing trainees were expected to gain descriptive knowledge as stipulated in the Acts and trainees were not expected to become active learners.

The training at nursing school controlled by NRB

The curriculum guideline from Nurses Registration Acts, 1920 and 1922
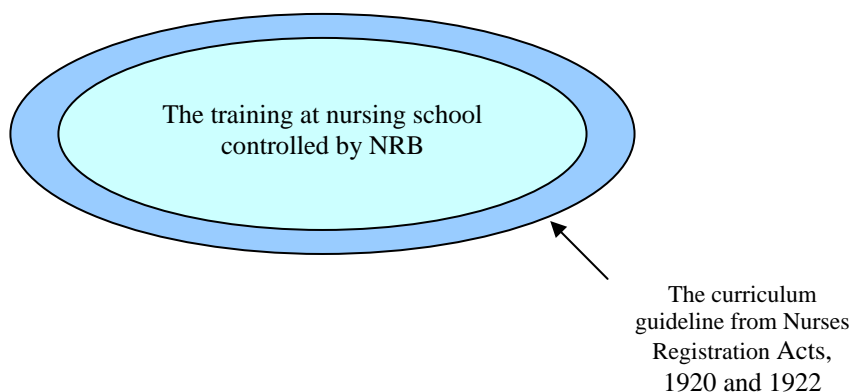
Diagram 14: The relationship between the school and NRB (1950s)

How were learning objectives set out in nursing training?

A further description of the training program shows that the foundation for nursing practice was firstly based on the normality and abnormality of the body. In other words, the nurse first learnt about normal anatomy and physiology of the body and then learned how to look after the diseased body by managing symptoms. For example, under the subject of Medical Nursing – twelve lectures (see Appendix 2), the subdivisions outline the 'general symptoms of disease' and explain the value of close observation. It is not known how the lectures were carried out, except for an emphasis on the abnormality of vital signs when the body is diseased. The focus was not on the importance of observation for the practice of nursing, but the importance of observation of the diseased body to be reported to others.

Moreover, sections on invalid cookery, housekeeping and hospital management were included in the training course. 'Housekeeping' implies house work such as cleaning, sweeping, dusting and polishing, etc. These tasks suggest that nursing role included domestic work and a text in common use at this time, interpreted these needs for training in housekeeping (Doherty, Sirl & Ring 1963, p. 13):

> It is to the advantage of the student nurses to have a working knowledge of domestic affairs, for when qualified, she [sic] may have to supervise the work of maids and assess the amount of time required for its satisfactory performance…

This explanation was written for the students who were training to be a nurse in the 1960s. The discourses in this text suggest how 'experience' was central in the training of nurses for their role as a registered nurse. As a registered nurse it was clear that knowledge about housekeeping was to be formed from doing the work, and that this would assist in their supervisory role as a Registered Nurse. Thus this text indicates that on registration the nurse would attain a place in the hierarchy, managing the work of others through her [sic] experience during training. Student nurses were exhorted to the advice in *Chapter 2: Advice to Student Nurse* (see Appendix 12), "Study should be linked with practical experience wherever possible. A mental picture of a procedure is of value" (Doherty, Sirl & Ring 1963, p. 7) and this method of study is based on the perception that development or learning in nursing is derived from experience and skill acquisition rather than knowledge.[102] These personal characters by training as a nurse represented the nurse's role as a skilled and good nurse within a hierarchical system (see more discussions in Chapter 3, p. 66).

Furthermore, in terms of who governs the program of the training school, the 1950s curriculum was controlled by the Nurses Board where the majority of members were medical doctors and administrators of hospitals. The written 'training' course indicates an orientation to medical disease treatment and management. Moreover, there was little space for a nursing school to form its curriculum,[103] and nurses (educators or others) were not expected to be involved in developing curriculum.

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[102] It wasn't usually linked. For example, in the block system in the 1960s orthopaedic nursing might be taught in 2nd and 3rd year but the trainee could be sent to work on the orthopaedic ward in 1st year. This was a problem in curricula where the focus was on nursing medical conditions rather than on nursing/caring for patients from a nursing perspective (as is seen increasing from 1970s higher education), (J Condon, 2007, pers. comm.,5 November).
[103] There was a suggestion for increasing the period of training for nurses from 3 years to 4 years training in the 1950s (Durdin 1991, pp. 145-9). The correspondence between NBSA and the matron at RAH describes the course and the financial costs of the course and the result was the duration of training was expanded to four years (Nurses Registration Board & Matron at Royal Adelaide Hospital 1947).

'Will' to control the curriculum

In this next phase, 'will' refers to a change in the control and construction of a curriculum. A further analysis of the terms used to frame the design and development of curriculum showed that the terms 'curriculum' and 'education' were more in evidence in texts produced by nurses and nurse educators as a part of their construction of curriculum. This more frequent use of such terms suggests heightened external influence from 'educational' knowledge on the internal processes in nursing education. This use of educational theories on discourses in nursing education was motivated, among other things, by the need to improve recognition of the nurses' role, retain nurses in the workforce and to educate nurses to perform their expanding role.

Shaping nursing education through saving time and place for student nurse

As I discussed in Chapter 5 (see p. 127), the motivation to change the nursing training system was high. However, nursing was still based in the hospital setting and nurses lived in nurses' homes and their individual lives and nursing training continued like this well into the 1960s. There were not many nurse training schools in the countryside in South Australia in the 1960s, so most young women who wanted to be a nurse had to come to the city for their training. The Royal Adelaide Hospital Nursing School had the highest intake. The trainee nurses resided in the Nurses' Home situated at the hospital and lived with other trainee nurses. Thus the time and place for nursing training was under control of the hospital system. This rigid and inflexible training system was criticised when the impact of the population increase after the Second World War created increased demand for health care workers, because it was seen as reducing the recruitment and retention of nurses.

The frustration of registered nurses (educators, managers and senior nurses) can be seen in the published texts of the 1950s. One of the texts queried the apprenticeship system of nursing. Peterson who attended the debate at the Australian Nursing

Congress[104], which was arranged by the College of Nursing Australia and held in 1955, Melbourne stated (1955):

> Nursing in Australia is facing a crisis and a satisfactory solution must be found quickly to prevent further deterioration with harmful effects to the community. In our opinion this condition is caused by a breakdown in the apprenticeship system of training, and this is no longer effective or adequate.

Peterson (1955) was disappointed by the situation in Australia and criticised the disadvantages of the apprenticeship system, such as the high wastage rate during training, and low job satisfaction due to the nurses' low professional status in Australia. The advances in technology and rising population had created a shortage of nurses.[105] Under pressure of high demand and changes in the level of knowledge needed in practice, the nurse trainee system was breaking down. However, such criticism remains implicit in this author's text as there is no explicit use of the terms 'student' or 'education', rather apprenticeship and training are dealt with in a negative way. Peterson (1955) goes on to suggest that the solution was to provide university education to prepare nurse leaders who were capable of providing nurse education, research on nursing practice and sound nursing administration. This debate prefigures the development of higher educational programmes for student nurses in Australia by some twenty years.[106]

However, there was much activity that was to build towards the development of registered nurse education in the higher education sphere. A nurse educator, who went on a study tour overseas for further educational system development, reported that it was not the right time to implement nursing education, in the 1960s, in Australia.[107] McKenzie (n.d.) recommended that a way forward was to establish educational colleges for nurse educators to obtain reform of the training system in

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[104] According to the author (not known), the Congress was also held with the conjunction with Australian Nursing federation and "It was the first such functions to take place in Australia" (1955, p. 16).

[105] This is also discussed in Chapter 2.

[106] Diploma programs for RNs commenced in 1949 at the College of Nursing, Australia, specifically for education and administration.

[107] McKenzie (n.d. p. 48) also explains that the intermediate certificate was not common among women. Yet, she claims that the present level of education was changing and nurses should not be left behind, when she wrote this report in the 1960s.

hospitals as a first step. This indicates how conservative nurses remained seeing that Registered Nurses would need to be well educated to make the changes needed in educating nurses in the hospital setting. In this vein, McKenzie believed that applicants would not meet requirements for tertiary education but foresaw that "if we envisage the educational standards of say, fifteen years from now, it is not unreasonable to claim that there will be the need for a degree in nursing" (McKenzie n.d., p. 48).

Establishing an educational system in which there was a designated place and time for nursing students to learn within the hospital system, was a key concept at this time. Establishing designated study time as 'Study Days' for student nurses was suggested by Durdin (1954, p. 36) with separation of the lectures and clinical practice days while student nurses worked at the hospital. She pointed out the benefits of this system:

> There is more continuity between theory and practice. For the average nursing trainee this is better than long periods spent in school, removed for a time completely from the nursing or patients.

Student nurses were recognised as the agents of learning nursing in the introduction of study days. While the need of nurses to be students for their training was recognised by Durdin, there is still an emphasis on the primacy of procedures and skills, as shown in the quote below, which Durdin outlines disadvantages of study days (Durdin 1954, p. 36):

> There are two disadvantages which have been experienced. The first is that for senior nurses the long period of two days away from the ward results in a loss of continuity of experience. For instance, the study may fall on a particularly interesting day, such as operating day in a surgical ward. The second disadvantage is that Study Day System has been found more difficult to administer.

As Durdin pointed out, nurses may miss out on an interesting operation day. The interest in operation points to a continuing medical perspective rather than the nursing perfective of looking after post operative patients. If the object of learning nursing was to focus only on learning about medical procedures, the continuity of

experience should not matter. In this sense the objective of learning seems focused on experiencing and knowing medical procedures and not in how to care the patients before, during and after the procedures. The focus is on continuing of experience, rather than continuity of care of patients.

The learning objectives in nursing still relied on a medical perspective and the place to study was still situated in the hospital. However the provision of study days was believed to facilitate filling the gap between theory and practice according to Durdin (1954). Durdin did not specify the meaning of 'theory' in her paper, but is most likely to imply theory as background knowledge on 'how to do skills' as she used the term to correspond with knowledge about disease, medical procedures and nursing skills. She commented (1954, p. 36), "I feel that in the time allowed, adequate theoretical instruction could be given and it would be related closely to practical experience". It was not till the 1970s in Australia that 'theory' might mean nursing theory relate to theorising nursing rather than theory (as classroom learning), distinct from practice.

Nurses' belief about theory in their education

Although there were arguments for a change in the system, assertions about the place of nursing theory were rarely voiced. This dominance of task-oriented nurse training shows how discourses blind speakers to the possibilities available at any time. This is evident in the lesser debate about newer concepts such as nursing as art, science, knowledge and the term 'nursing curriculum' being used more frequently. In this new atmosphere, Smith (1962, pp. 30-4), who was the Senior Tutor at Royal Alexandra Hospital, presented a paper in 1962.[108] She questioned the general nurse curriculum criticising its lack of a theoretical component and repetition. Using and re-surfacing ideas she had found in Nightingale and describing 'nursing as the finest of fine arts', Smith also questioned the absence of a body of nursing knowledge and claimed that art is essential to nursing. Along with the importance of art in nursing, Smith also saw an accompanying significance of science to nursing education and

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[108] The paper was presented at the 27th Annual General Conference of the Institute of Hospital Matrons of New South Wales and Australian Capital Territory.

practice. Smith described in the paper how science can contribute to nursing (1962, p. 30):

> A science is a body of knowledge based on a large number of carefully collected facts which have been arranged and classified in such a way as to establish certain laws and principles. Nursing as a science requires a broad basic education and a through knowledge of human nature. The sciences are the foundation stones on which basic nursing stands firmly – anatomy and physiology, physics and chemistry, pathology, microbiology, pharmacology, nutrition, sociology and psychology. When a nurse joins this scientific knowledge with a skilfully executed procedure, her work becomes really effective.

Smith regarded science as an essential element for nursing and believed in bringing knowledge into nursing from other disciplines. She did not comment about a way of establishing independent theory in nursing or establishing nursing as a discipline, but argues for bringing other disciplines into the nursing curriculum. The statement below suggests that nursing in this period was still descriptive and functional, and based on repetitive training. Hence, her suggestion for nurse education focused on introducing borrowed knowledge and reducing the repetitive curriculum components. Smith put this as follows (1962, p. 34):

> An oft-repeated criticism of the present curriculum is that there is too much repetition. Is not this rather a fault of interpretation than of the curriculum itself? With careful thought and planning this repetition can be eliminated, leaving more time for changing trends and understanding of [sic] nurse/ patient relationship.

Her critique of the curriculum also pointed out the need for discussing social change and having more time for the foundation of nursing – the nurse/patient relationship. Smith's critique marks the appearance of two concepts – 'changing trends' and 'understanding of nurse/patient relationship'. The first highlights an external element to nursing and the other, internal to nursing as she brings a new focus to the relationship between patients and nurses. Smith provides evidence of a shift from purely task-oriented nurse training to one taking account of the relationship between patients and nurses in practice. It should be noted that at this time, the theoretical perspective of nursing was not common in the debates about nurse education, rather these fuller developments would need to wait for the move to education in the tertiary sector and to a focus on professional education only possible through a belief that a body of knowledge was central to recognition of professional status.

On the other hand, in the USA Johnson (1959) argued for the importance of theory development in nursing in gaining disciplinary status. She also claims the purpose of theory as providing a means to communicate in a professional community. Thus her emphasis on the importance of theory is related to nursing professionalisation. Johnson (1959) argued the purpose of theory in this way (p. 219):

> Yet it is a question of considerable significance for nursing's continued development as a recognized professional discipline. Certainly no profession can long exist without making explicit its theoretical bases for practice so that this knowledge can be communicated, tested, and expanded.

Johnson insisted on the importance of science to the nursing profession and the importance to its development being communicated using the common language in discipline to promote professional knowledge, which was also based in the well-rehearsed understanding about profession at this time.[109]

Nurses take responsibility for curriculum

In South Australia, as described previously, nursing training was hospital-controlled and the training course was regulated with standards set by the NBSA. Following an amendment to the Act in 1962, the curriculum guidelines for general nurse training in 1966 showed that the topics came from a variety of disciplines such as physics, chemistry, sociology and nutrition, and the content of these subjects was systematically outlined.[110] For example, in the topic of nutrition, things such as food constituents, diets for age groups, preserving food, presenting food and special hospital diets were taught. Although there is no record of how these topics were delivered, it implies that there was still a norm that nursing education was content and task focused. What was set to learn in order to be a nurse indicates that

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[109] For example, see Chapter 2, page 31 in Parsons' discourse of profession.

[110] In 1962, NBSA revised the curriculum and led "the first changes in subject matter in syllabus, the outcome of a revision of the syllabus undertaken by the Tutor Section of RANF" (Durdin 1991, p. 190). This amendment introduced the Preliminary Training School (PTS) course. It was designed to provide educational experience for four weeks with paid work time (see details in Durdin's *They became nurses*).

curriculum was seen as a 'body of knowledge' to be presented to the student, and as such was a content-driven and knowledge-centred curriculum.

In the section on fundamental nursing in the curriculum guidelines (see Appendix 7), there is a section called 'The patient'. The context of this term was described as a "sick person, environment of patient, physical comfort, mental comfort". There is no explanation regarding this term 'the patient', however the role of nurses and how nurses see the patient was expected to be included in the curriculum of the nursing schools. Although this seems to be evidence that there were notions of patient-centred nursing implied in understanding the patient, how this idea from the Nurses Board was included in the actual curriculum and how it was delivered is not known due to the lack of data about details of subjects taught in school or other archives.

The notion of patient-centred nursing with medical subjects such as surgical and medical nursing, considered as essential components of curriculum. They were also components of pre-examinations in preparation for the NBSA controlled final examination. Nevertheless, affordability of time for nurses' education and the place to teach and learn nursing, were a critical issue (see also p. 167 in this chapter). How well prepared a nurse was depended on the attitude of the school administration and availability of the resources of the hospitals. As Nicholson (1992, p. 14) described this:

> Thereafter the quality of nurse education was heavily dependent upon the commitment of the hospital board to the school of nursing, the nursing tradition of the institution, and the financial status of the hospital.

Her description of the relationship between the hospital board and the school of nursing indicated how the nursing school relied on the hospital board and nurses' attitudes toward nursing. For example, how nurses interpreted the role of the nurse at that hospital would be dependent on their socialized specific hospital training experience rather than on their use of a broader nursing knowledge. Traditionally, nurses were rarely seen on hospital boards, the membership composed of medical doctors and administrative officers. Thus, the role of nurses and the education

(training) of nursing students improved only slowly.[111] Durdin (1999, p. 143) wrote about the change in nursing education at the RAH:

> Until 1967 the Nurses Board had controlled the lecture program for general nursing training and had appointed lectures for each of the four subject areas. In 1967 the hospital board took over this responsibility. It delegated this work to the staff of the Nurse Training School, which early in 1968 became known as the School of Nursing. (Based on RAH Annual Report 1967).

These gradual shifts of responsibility from the Nurses Board to Nurse Training Schools imply that the regulation of nursing profession was gradually being delegated to nurses. The nurse training system shifted so that the school defined what kind of nurse it wanted to educate according to the NBSA guidelines. Having the right to decide what and how to teach was significant, even within the constraints of the NBSA guidelines and hospital based education. For example, the RAH assessment criteria (see Appendix 3) describes the character of students: reliable, generous and having powers of observation, etc.[112] These graduate attributes indicate how the nurse educators perceived the role and attributes of nurses. Although the training school had some autonomy in how nurse students should be assessed, the criteria contained personal and organisational characteristics rather than professional characteristics that will be seen difficulties in later developments.[113]

The professional definition of nurses was undergoing a process of change. Nurses and nurse educators gradually took responsibility for nurse education. This change can be seen in Diagram 18 and is located mainly in the relationship between the school and NBSA. The school started to be independent of Nurses Board control,

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[111] The financial argument between establishing the nursing school and the hospital will be also exemplified in the establishment of Sturt College later years (see pp. 74-6).

[112] The characteristics of students were also discussed in Chapter 3. It is my intention to focus on what counts as professional criteria here, which also discussed in Chapter 2.

[113] Nelson (Phillips 2007) talked about this difficulties on a radio, "…the whole cost of education [of the hospital based training] when you're starting to meet standards of well-developed curriculum where you had to rotate students in all number of areas and if you don't have those areas within your hospital, you've got to have them go to other hospitals to get those kind of skills. When the hospitals started to cost that, as we started to cost everything I suppose in the '60s and '70s, they realised that it actually wasn't worth the money for them to be funding a lower qualified person, and in fact they really needed to start to work with a registered nurse basic workforce, and that only started to happen in the 1970s in Australia".

although the Board still defined what needed to be included in the nursing curriculum. However nursing students still had to attend the lectures and study days with some payment.[114]
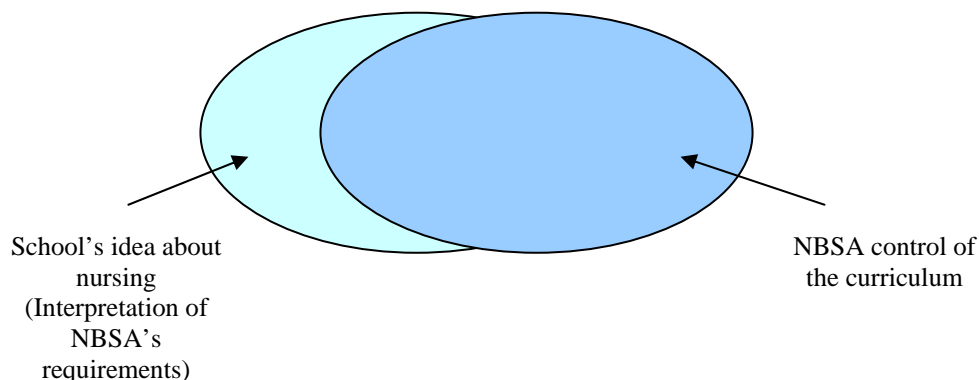
Diagram 15: The relationship between the NBSA and the nursing school in the 1960s

First steps to educational control of the curriculum

The separation that occurs over nursing curriculum governance indicates changes in the relationship of curriculum stakeholders, including nurse educators, hospital administrators and medical doctors. In this phase, hospital-based nurse educators became more responsible for constructing curriculum. Nurse educators, who were nurses, explored their role more fully. The role of nurses in the 1970s was described in Chapters 2 and 3 and during this period the emphasis remains on nurses' organisational and social roles. The federal government report known as the Sax Report (Committee of Inquiry into Nurse Education and Training 1978) noted the stakeholders in nursing education[115] as hospital and health administrators who

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[114] It is interesting to see the changes in the new curriculum offered at Adelaide University in 2006. The curriculum offers more clinical components. The curriculum describes the clinical placements: "One of the most important strengths of this innovative program is the substantial amount of time dedicated to learning in practice. This clinical time is significantly increased" (The University of Adelaide 2006). In this sense, the meaning of education is more about gaining hospital experience at the one hospital again. And they may have to be paid again as students to take account of how they may not be able to work to support their student status.

[115] The report was called "Submission to the committee of enquiry into post-secondary education in South Australia" (The College of Australia, S.A. State Committee & Royal Australian Nursing Federation 1976).

financially controlled the institutions, the medical doctors who work closely with nurses in the clinical setting, teachers at the colleges and nursing students who were learners. Considering the range of stakeholders, in seeking for the control of the curriculum to be with the educators and the student, the place where nurses trained had to be relocated. College of Advanced Education based nursing education commenced in South Australia in 1975 with complete transition in South Australia in 1993.

The meaning of location for nursing education – the case of Flinders University

The stakeholders in the nursing curriculum who had different views about nursing were in conflict. In the early 1970s there was a plan to establish a new hospital in the southern region of Adelaide. Aileen Monk was the Director of Nursing at that time at Flinders Medical Centre, when it was decided that this new hospital would not train its own nurses. Nurse education became collaboration between the Medical Centre and Sturt College of Advanced Education. Professor Gus Frankel recalled this transition:

> I realised that [sic] we had struck here and that Aileen Monk was a very advanced thinker, and as much as any nurse, amendable to new nurses and persuasion, and so on. However, when she struck this side of educating her students at Sturt, she was exceedingly alarmed and very worried. Because, well, you know how they [hospital staff] felt about college trained nurses at that time. They wouldn't know how to make a bed.[116]

As he had been involved in medical and nursing education for a long time, his opinion was interesting (Linn 1997):

> I think if you are going to do what happens now – have the people educated at CAE [College of Advance Education]'s and wearing jeans and whatever and feeling (?) themselves as students, and they spent two weeks here, and two weeks at Noarlunga, and two weeks up in the north somewhere, and whatever, they miss a lot. Nursing and medicine, they're still – it's a hospital culture which you learn only by being of it and in it.

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[116]Cited from "The oral history of the Flinders Medical Centre History Project" at the South Australia State Library, J.D. Somerville Oral History Collection (Linn 1997).

The context 'being there and being of it' in his recollections shows his belief that learning occurs best in a certain environment and this was based on the assumptions of an apprentice model of training. There was also an assumption that nurses should stay in one hospital to learn its culture and the demands of doctors rather than to learn nursing. In this sense, he expected that the place where the nursing students could learn was limited to hospital settings.[117]

How was nursing explained through nursing process?

As I discussed in Chapter 4, problem-solving discourses generated opportunities to accelerate nursing knowledge development. Not only did medical technology promote re-definition of nursing, but also theoretical development (for example, by Peplau, Orem, Johnson, Rogers and Weidenbach, and other nursing theorists) that occurred from the 1950s. The demand to theorise nursing practice grew in the 1960s. Brown who was a nursing academic in USA (1964, p. 110) insisted on the development of nursing theory and reported on 'patient-centred nursing' research. Based on the belief that nursing starts from the relationship between nurses and patients and nursing is the care of patients, theorisation of nursing was thought to demonstrate that nursing knowledge is unique and to differentiate it from medicine (Brown 1964).[118]

I explained two concepts of nursing process in Chapter 4. One explains that nursing's role and function resides in the relationship between patients and nurses. The other views its importance according as problem solving with a scientific and managerial perspective. The concept of 'nursing process' was introduced for describing what nursing is, and began appearing in various texts such as government reports, curriculum and organisational reports to describe nursing practice. The 1978 Sax Report (Committee of Inquiry into Nurse Education and Training) used the term 'nursing process' to describe nursing. Nursing process in the report was described in

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[117] It is understandable that Professor Gus Frankel recalled the situation in the 1970s when the nursing school was founded, that the concept of nursing as yet did not include a community focus. Although acute care in the community was provided by the Royal District Nurses Service (RDNS), it was not primary health care focused. Community health centres were established by the Whitlam government in their 1972-74 term.

[118] See also discussion in Chapter 4, page 118.

the chapter *Nursing roles and functions*. It says that the functions of registered nurses are divided from 'the simple skills based on common knowledge' to 'complex ones needing expert skills and judgement'. The steps of nursing process were described under section 7.3 (1978, p. 50), 'The registered nurse is required to – (i) plan, implement and evaluate the nursing care appropriate to the nursing needs of individuals'.[119] Thus, the introduction of the nursing process allowed nursing to possess the means to define nursing practice although the report itself did not promote changes to the nursing education system.

Dunlop (1992, p. 65) investigated the inclusion of the nursing process curricula in nursing schools and found seven Colleges of Advanced Education out of 16 institutions in New South Wales used it.[120] She described how nursing process was "an organiser for the nursing major" (p. 64) and that it helped to organise curricula without using medical or traditional models. Dunlop described the usefulness of nursing process in the nursing curriculum as a thinking tool for nursing in the curriculum to promote nursing education. At the same time as a nursing course was beginning in a College of Education in South Australia, various texts described the introduction of 'nursing process' into nursing curricula (this will be analysed in next chapter). As the place to learn and teach became instituted in a tertiary setting, the thinking about nursing became set in a problem-based approach to nursing practice. With these components nurse educators became more autonomous in designing the content of the nursing curriculum in terms of what and how to teach nursing students. Diagram 16 mirrors this changing attitude to the curriculum and shows the relationship between the curriculum, Nurses Board guidelines and the school regarding nursing and nurses in the 1970s. The distance between the organisations is greater than in Diagram 15 (p. 175) and the area controlled by the Nurses Board more limited. How nurse educators interpreted nursing and the kind of tools they used to do this was reflected in the curricula during this time.

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[119] The report was read by nursing professionals and it outlined the slow process of introducing nursing education to the tertiary sector. Russell (1990, p. 129) writes: "profoundly disappointed at the proposed slowness of the transfer of nursing education into the tertiary sector". This report also recommended rationalising and upgrading the existing hospital schools of nursing, to close down a large number of small and inefficient schools, and to establish a system that linked the hospital-based nursing school and school of nursing.

[120] Educational institutions includes Institute of Technology, Institute of Advanced Education at Universities (Dunlop 1992, p. 97).
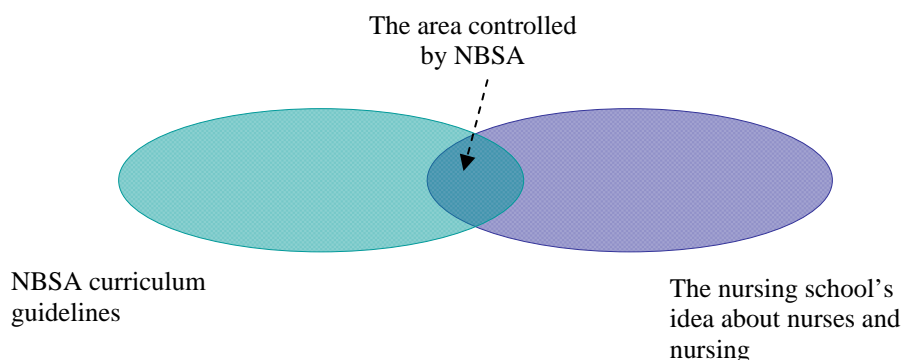
Diagram 16: The relationship between NBSA and the nursing school (1970s)

Curriculum at Sturt College of Advanced Education

In overcoming conflicts in terms of economic and social threats to nursing education, nursing slowly increased its autonomy[121] – being independent about nursing and the place to teach and learn, as well as gaining student status for undergraduates. After much discussion, the establishment of a tertiary level school in South Australia at the Sturt College occurred in 1974 with the first students enrolling in 1975. The aim of the course is described with the definition of nurse (Sturt College of Advanced Education 1976, p. 7):

> …The combination of care for the sick and education and intervention to provide preventive care for others is acknowledged as appropriate to contemporary nursing. This kind of practice requires skills and knowledge additional to those that have been traditionally acquired within a general nursing curriculum...

While there is a clear aim for education, there is no stated school philosophy. The stated aim shows the educators' belief in nursing education gained through both skills and knowledge, based in traditional education, but also in preventative care with a health focus not found in traditional education. So in this new location, nursing has a dual focus in illness and health. The curriculum promoted eight objectives for students to achieve, which makes the nurse educators beliefs clear (Sturt College of Advanced Education 1976, p. 7):

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[121] The transition of nursing to the higher education sector is also discussed in Chapter 3.

(a) To <u>develop competence in providing nursing care in a variety of settings based on a thorough knowledge</u> and understanding of scientific principles applicable to nursing;[122]

(b) To assess nursing needs, plan and implement appropriate nursing care, and evaluate the effectiveness of the intervention according to basic nursing principles;

(c) To develop skills in establishing and maintaining effective interpersonal relationships;

(d) To develop <u>attitudes and values which will enable the nurse to function at a professional level as a member of the health team,</u> and help towards attaining satisfaction in personal and professional life;

(e) To develop skill in using problem-solving techniques, communication skills and other basic processes of administration in nursing, and in planning, organizing and supervising the work of others**;**

(f) To appreciate the value of and be able to participate in research in nursing;

(g) To develop skills in teaching, both directly and by example, in order to assist patients and clients to recognize and take responsibility for aspects of their own health care and to ensure continued good nursing care by teaching less experienced colleagues and students;

(h) To recognize the need to use basic nursing knowledge as a foundation on which to build by means of continuing education.

These objectives were also the graduates' attributes as nursing professionals. In section (d), the graduates were expected to possess professional attitudes and be able to function at the organisational level wherever this organization may be. The relationship between the patient and nurse is also clearly stated. No longer are there descriptions of 'doing to the patient'. There is also a shift in the role of nurses from a focus on individual behaviour to organisational.[123] This behavioural change brought nurses to possess the context of professionality such as autonomy, responsibility and accountability. [124] These descriptions are positioned by both social sphere and professional sphere of discourses to produce professional nurses.

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[122] Underlined by SCAE.

[123] This shift is explained in Chapter 3 in the section of 'A nurse as a member of the health care system'.

[124] This is also discussed in Chapter 2 as Discourses of professionalisation.

Autonomy, responsibility and accountability – professionality in a curriculum

As I mentioned the term 'responsibility' and 'accountability' is more often used in texts such as the competency standards in 1990 (see Chapter 2, p. 41). Although these terms were not explicitly mentioned in this curriculum, the description of activities and role of nurses imply these nursing professional attributes. For example, in the school's objectives as previously described (see p. 179), "develop competence in providing nursing care in a variety of settings based on a thorough knowledge", and "develop attitudes and values which will enable the nurse to function at a professional level as a member of the health team" contains the sense of cultivating accountability, with professional knowledge and attitudes established in a set of codes, regulations and shared understandings. Furthermore, these attributes are implied in inter-profession interactions. The context of a professional attitude is no longer based on the personal characters of the nurses such as obedience, loyalty and punctuality.

Positioning nursing knowledge in curriculum

Nursing, it is claimed, is now guided by scientific knowledge. In point (b), the steps of nursing were as follows: "assess nursing needs, plan and implement appropriate nursing care, and evaluate the effectiveness of the intervention according to basic nursing principles". Although the term 'nursing process' is not used, these steps outline the nursing process as defined by Yura and Walsh (1973). In section (e), the problem-solving 'technique' was expected to be familiar to graduate nurses. The term 'technique' implies that a 'tool' was used in nursing. Thinking tools such as the problem-solving approach, nursing process, etc., influenced nursing to apply scientific concepts. In fact, problem-solving skills are emphasised through the curriculum, although the term 'nursing process' was not introduced into the curriculum at this stage. I described how nursing knowledge developed in Chapter 2 (see p. 48-51); the use of thinking tools for nursing is an assimilationist approach to nursing knowledge development. Nursing knowledge assimilated ideas from other disciplines, especially bringing in the scientific approach to nursing. On the other

hand, a separationist approach would be used in later years in the Australian context.[125]

The emphasis on 'problem solving' was described in the correspondence between Anne Pickhaver who was the Senior Lecturer at Sturt College of Advanced Education, and K. O'Reilly who was the Principal Nurse Educator at Mater Misericordiae Public Hospital in Queensland (O'Reilly 1979).[126] O'Reilly expressed interest in the curriculum at Sturt College and she wrote in 1979:

> It is with much interest that my colleagues and I have read your submission of August 1976 to the Board of Advanced Education of South Australia relating to the proposed course of the Diploma of Applied Science (Nursing). At the present moment, we are attempting to develop and plan a new curriculum around a central theme incorporating human needs, problem solving and developmental stage of man [sic], and we are particularly interested in the approach you have taken…

The purpose of the curriculum according to O'Reilly was to show that nursing was not disease centred but human centred. This implies that the concept of nursing had shifted from the medical model to care of the person who was ill, where needs were defined more broadly. Pickhaver replied (1979):

> ...Our aim is that students will use a problem-solving approach to nursing. We teach the concept of the Nursing Process to achieve this, based on an appreciation of human needs. Whereas in 1975, with one group of students and a small group of lectures, it was relatively easy to integrate the teaching of nursing and the basic sciences, we found in succeeding years that this did not happen so readily. We have recently conducted a workshop to explore this problem, and have planned some combined sessions in the first year of the course…[127]

Pickhaver answered by emphasising the problem-solving approach in nursing. It is noteworthy that she used 'appreciation of human needs' in terms of nursing process. Comparing this to the divergence of the concept in Chapter 4, Pickhaver seemed to

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[125] For example, nursing theories, seen as underpinning nursing as a discipline were actively argue for in U.S. in earlier years.

[126] This letter is dated on 9th October 1979 addressed Mrs. Anne Pickhaver at the Sturt College of Advanced Education.

[127] This letter is dated 13th December 1979 and posted to Miss K. O'Reilly at Mater Misericordiae Public Hospital in South Brisbane.

use the term 'nursing process' with great care as a part of a nursing curriculum. The term 'nursing process' was not used when the school begun. Although it was only mentioned in the letter, the spread of the nursing process in this era influenced the teaching of nursing and it produced a dilemma for teachers which will be discussed in the next section.

The dilemma of teaching nursing process

The new way of understanding the concept of nursing - nursing process – created a dilemma for nursing education. Although nursing longed for definition, the 1970s texts highlight certain issues regarding the concept of nursing in nursing education. At a workshop in 1978 at Sturt College (Sturt College of Advanced Education & Flinders Medical Centre 1978), the issue of nursing process was discussed. The workshop report stated, "The overall aim of the Workshop is to try to solve some of the longitudinal integration problems that appear to be causing students and staff concern in the Diploma programme". One of the issues to be discussed was: "References to and use of the Nursing Process as a framework for teaching, learning and assessment of both nursing and the supporting sciences". The confusion over the nursing process was discussed in the workshop, for example (1978):

> The 4 processes described as 'the nursing process' are innate in all individuals; pity that nursing chose to be associated with these. Possibly problems arise with students since not enough time is spent on the steps of the nursing process. Often students are not exactly sure what is meant when the steps are spoken about….Students often think these steps are carried out at a particular time of day (i.e. assessment in the morning), which is wrong.

Two implications of this comment are important. One is the resistance to nursing process and the other is the confusion that arose in accommodating this process into a practice setting where it was used rarely. There are also clearly contentions unlike the picture prescribed by Yura and Walsh (1967, 1973) in the previous chapter. These statements imply that the nursing process is seen simply as a problem-solving technique which should not have to be taught, because it is an innate process and yet on the other hand is not taught well enough for students to be able to apply it. The text also implies that a resistance to the idea of nursing as problem solving of

'known-problems with known-solutions' and rejection of the idea of a 'tool', with a preference on a focus on processes of thinking. This rejection of using the Nursing Process as a 'tool' is explicit in the text as the opinions from teachers at the school (1978, p. 2):

> We must be sure it is individualized care and to emphasize that every patient's needs are different. We must teach this process such that we get it over to the students, that is, that we want them to learn about the process.

The process should be used in their opinion for finding out the individual patient's needs rather than for problematising the patient. The intention of teachers at school is not to use nursing process as a tool, however the guidelines of the authority imposed this approach. In the NBSA's curriculum guidelines report (Nurses Board of South Australia 1979, p. 3), the curriculum guidelines' revision was explained as one of the considerations:

> The need for a model which could be used for most areas of the curriculum and would be unlikely to become rapidly obsolete led to the adoption of the nursing process.

This comment justifies the NBSA's suggestion to use the nursing process in a curriculum, educating professional nurses who, "implement the nursing process in a variety of situations with patients/clients, who have potential or existing health problems, to promote, conserve and restore their optimal level of health" (NBSA 1979, p. 9). It also reflects a confusion between nursing process and the grand theories (models) of nursing which were becoming better known in Australia. This confusion was referred to in Chapter 4 (see p. 109, 'Yura and Walsh's nursing process as nursing rationality'), in discussing Yura and Walsh's linking of the nursing process to theories (models) of nursing.

It (SCAE 1978, p. 2) stated, "why the nursing process? It is our [SCAE] guidelines, therefore we are stuck with it. Maybe a State commitment re registration".[128] It is not certain, but likely that this statement is made about the NBSA's guidelines, with the

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[128] This is from the 1978 workshop concerning the issues such as referencing the Nursing Process, using the Nursing Care Plans assessing the students and competencies in the Diploma of Nursing.

authority influential in how nursing could be taught. Although the nursing process implementation was accelerated by the NBSA, the SCAE seemed to consider the process as a tool to improve problem-solving ability, as Pickhaver suggested in her letter previously. [129] In the 1970s the course topics emphasised improving the acquisition of problem-solving skills, rather than the use if a specific published process.

Secondly, implementing the nursing process led to confusion as described in the report. The students saw the nursing process as a tool. Moreover, they did not understand nursing process as a process of thinking about nursing. It is possible for nursing students (and other nurses) to take nursing process as a tool and utilise it as the rationalisation of nursing; the patients are problematised and nurses are problem solvers of patients' bodies. This approach is against Orlando's use of nursing process, which emphasised the relationship between patients and nurses to achieve thoughtful application (not automatic) by students of the techniques of nursing. The introduction of the nursing process saw the role of the nurse become interventional and outcome-oriented, much as medicine is in contemporary health practices. Thus, the discourses of the use of the nursing process and problem-solving approach in curriculum is discursive by shifting the focus to what it is used for; achieving the students' learning about a process of nursing, articulating the problems in patients and knowing how to deal with them. The ambivalent interpretation of the nursing process and other tools such as problem-solving approach are seen in texts. In the next section, I will discuss the topics that employed 'problem-solving' from the curriculum and investigate how they were used.

The topics using 'problem-solving' in the 1970s

The term 'problem-solving' was found in the 1970s curriculum booklets. In the curriculum, the thinking tools such as 'problem-solving approach' and 'nursing process' were first applied in the South Australian nursing curriculum. I summarise the ways in which the term 'problem-solving' in the 1970s in Table 4 below.

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[129] Pickhaver et al. (1985) also conducted a study on the new graduates of SCAE. The study assessed the quality of nursing education in education by using questionnaires and concluded that in terms of their thinking and responses to questions.

Table 4: The appearance of the 'problem-solving' in the 1970s curriculum

Year	Sources	The sentences used the term 'problem-solving'
1976	One of the aims of the curriculum proposed for the Diploma of Applied Science (Nursing) booklet (p. 9)	To develop skills in using **problem-solving techniques**, communication skills and other basic processes of administration in nursing, and in planning, organizing and supervising the work in nursing.
1976	The health-illness spectrum in the first year:	The student begins by studying man [sic]'s basic needs and is guided in the development of skills required in the assessment and identification of these needs, and in the planning and implementation of nursing care which will aid in the maintenance of health and prevention of illness…During this time, the student gains insight into the nursing process and is guided towards a **problem-solving approach** to patient care. The patient need fulfilment is the basis for procedural practice.
1976	In the second year topic adult care module, one of the unit objectives describes that after the completion of this module, students should be able to:	…demonstrate more complex skills in **problem-solving** to assess patient care priorities and measures to support the action of any medication.

Through the implementation of the problem-solving approach in curriculum over the years, a belief in cultivating the problem-solving approach to educate a professional nurse emerged and the ability to use and apply the approach in nursing is emphasised in the topic descriptions. The thinking tools such as the nursing process and problem-solving approach as these operated in the curriculum expects nursing students to be armed with these skills as professionals. Hence, the 1976 curriculum was partially based on the objective, which expected the students to possess these thinking tools to achieve professionality. In this sense, the curriculum is seen as the checklist to be a nurse (see Chapter 5 'Curriculum as product', p. 142).

The use of the nursing process in the governmental report shows understanding of nursing in the social sphere discourse. For example, nursing, as consistent with the elements of the nursing process was seen in the discourses of the Sax report in 1978 (see Appendix 14). The professionalisation project by applying the nursing process into nursing education (curriculum) created a dilemma for nurse educators (see p.

182), to teach nursing relying on the process but preserving the patients' individuality.[130]

The role of NBSA in change – its response to the nursing process

I previously mentioned that the *Curriculum and guidelines for general nurse training in South Australia* (Nurses Board of South Australia 1979) provided information regarding the implementation of the nursing process. The curriculum guidelines sought to develop professional nurses who are able to "implement the nursing process in a variety of situations with patients/ clients, who have potential or existing health problems, to promote, conserve and restore their optimal level of health" (p. 9). The Nurses Board noted that the guideline were "not a programme" but "a guide to help in the ongoing development of school programmes" (p. 3). Therefore, the guidelines reflected the school's autonomy and the educators could interpret the guidelines.[131]

The training course requirements for registered nurses were strictly regulated under NBSA regulations before the nursing school (i.e. college-base school) was established. The college nursing education system was responsible for its own students, previously a responsibility of the NBSA, and as a result, the context of the course became more flexible in terms of the ways in which nursing was taught and assessed.[132] Nurses and nurse educators are able to decide what they teach and how they teach nursing at the school as I mentioned in the previous section "the guidelines reflected the school's autonomy and the educators could interpret the guidelines" in their ways. Thus the attributes of nursing professionals depends on the nurses' and educators' expectations.

Consequently, the NBSA's role changed from 'assessing the graduate nurse' to 'supervising and accrediting the standard of the college curriculum'. The intervention

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[130] See Appendix 10. As the curriculum stands of shows, nursing is not only driven by the thinking tools. It was also based on the nursing theories such as basic nursing, medical/surgical nursing and skills of professional nursing.

[131] However as was seen in the workshop report (1978) alluded to or nurse educators were unclear about this level of autonomy in designating the curriculum.

[132] Also described in Chapter 3.

of the NBSA on the nurses' education became more indirect. This process was described as delegation of power to the educational institution. However, the definition of nursing profession in terms of ability and what kind of nurses are required in society, and which requirements also influenced nursing education to be professional, was assessed and standardised through the NBSA.[133] Although the role of NBSA was changed, control over nursing professional standards was still in the hands of the NBSA as set by the Act. Nurses and nurse educators had opportunities to teach nursing in their ways and belief, on the other hand they were constrained by a new form of standardisation formed by the requirement to match the nursing standards.

Although there were controversies with the introduction of the nursing process into clinical and nursing education, the nursing process was utilised as a tool for management and systemizing of care for institutional convenience and quality assurance in patient care. In the following section, the response from practising nurses toward the nursing process will be described.

Response from practising nurses - the difference between education and practice

The expansion of nursing process in South Australia was evident in a letter by Genevieve Gray, who was a professional officer for the Royal Australian Nursing Federation in 1981 (Gray 1981). She wrote to the course co-ordinator at the Sturt College of Advance Education regarding the Diploma of Teaching (Nurse Education) course:

> …the Royal Australian Nursing Federation has implemented a national programme to promote the introduction of a problem-solving model for patient care and the concepts of quality assurance programmes through the conduct of workshops. The R.A.N.F. (S.A. Branch) Quality Assurance Committee has conducted workshops in South Australia during 1979-1981 and the introduction of the Nursing Process has occurred and is occurring, in hospitals, nursing homes and community nursing agencies…It

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[133] ANCI was established in 1992. The function of the organisation is to create a pathway to nursing and midwifery regulations. The ANMC works with state and territory Nursing and Midwifery Regulatory Authorities (NMRA) in developing standards of statutory nursing and midwifery regulations. These standards are flexible, effective and responsive to the health care requirements of the Australian population (ANMC 2006b).

> has come to the notice of the Quality Assurance Committee that "Nursing Process" is not being incorporated into the Diploma of Teaching (Nursing Education) programme….I believe that it would be useful if members of the quality Assurance Committee could meet with the appropriate persons from the Education Course to discuss strategies to overcome the problem which is causing concern to the profession…

The nursing process was rapidly applied to nursing practice at a time when there was a high demand for systematising the nursing care system, in order to improve quality of care. McKechnie (1981) writes an article titled 'The nursing process - revisited' in *Inforum – A Journal of Nursing Practice and Nursing Issues* – published by the Royal Adelaide Hospital. She explained the nursing process steps and supported the use of the nursing process to focus on meeting patients' needs in an organised manner. It seems that the nursing process was seen as encouraging patient-centred nursing care, in spite of the concerns expressed by the nurse educators at SCAE in the 1978 workshop. The Flinders Medical Centre used the nursing process for planning care.[134]

What was the reaction of nurses toward the nursing process? When nurses heard about it, Yura and Walsh (1973) described nurses' reaction as being that they already used it, and that this was the same process as the research process (Yura & Walsh 1973). They wrote, "Indeed, the solutions to certain problems can only be found through research. However, a large number of daily activities in nursing can be resolved by problem-solving techniques" (1973, p. 20). The overuse of and misinterpretation of the 'nursing process' between practice and education caused a new debate because practice and education have different perspectives.

The tension between practice and education surrounding nursing process

The introduction of the nursing process into nursing education and practice came from different goals. From the educational perspective, nursing process was used as a framework for teaching ways to think about nursing and the application of theory to

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[134] The workshop report in 1978 (Sturt College of Advanced Education & Flinders Medical Centre) showed the discussion of the nursing care plan at Flinders Medical Centre in terms of the purpose of its use.

practice. On the other hand, the introduction of nursing process into practice was to improve the quality of nursing. These differences created confusion and discussion during the 1980s as I discussed in Chapter 4. Details regarding the nursing process in the curriculum in the 1980s will be explored in a later section.

In the nursing practice field, Kaye Challinger who was a clinical nurse at Royal Adelaide Hospital in the 1970s, recalled the introduction of nursing process during the 1970s:

> I think the nursing process was the most profound change because what it did was challenge the work that you were doing, and I can vividly remember being a thorn in some people's sides at the meetings that we had to attend – they were compulsory…I was a clinician who was being told that I didn't know how to assess patients or evaluate them because I didn't do it in the steps. That was our perception. So I think it really was a challenge to the clinicians' credibility and their self-worth…(Durdin 1997).

As Challinger recalled, the nursing process promoted nurses' reflection on their daily nursing practice. The reflection process made nurses monitor their nursing more than ever before but also created some resistance early on (see the previous discussion at nursing college regarding teaching nursing process, p. 182). Moreover, the concept divergence of nursing process as I discussed in Chapter 4, meant the nursing process came to be utilised in the hospital setting as management tool. The tool was used to legitimate nurses' work at hospital to be a professional in this phase. To promote the application of nursing process in practice, a workshop was hosted by Australia Nursing Federation South Australia (ANFSA). Correspondence between the ANFSA and the school reflected the high demand from practicing nurses to implement the nursing process.

Chapter summary

In this chapter, I explored curriculum development from the 1950s to the early 1980s and described how the curriculum changed. The curriculum changed from being dominated by medical doctors and hospital administrators, to one defined by nurses and nurse educators. I pointed out four elements that made this shift possible. Firstly,

there was the location where nurses would have their 'education'; not only the physical space but also the time to spend doing nursing practice. Secondly, the status of 'student' was guaranteed in nursing professional education in the tertiary sector. It allowed a nursing student to be recognised as 'a learner', not 'a trainee'. Thirdly, thinking tools in the nursing profession were utilised in nursing education. The nursing process was the most influential tool for both nursing education and nursing practice. It led to a divergence between nursing education and practice in terms of the purpose of its use. Nurse educators saw it as a process of nursing to promote nursing students' learning about nursing, centralising the relationship between the patients and nurses. Nurse practitioners saw it as the nursing process to manage nursing care.

This divergence of the concept continues to be discussed in the different form of discourses by nurses. Thus nurses are able to define and discuss nursing through their debates and communications. This is the fourth element – gaining autonomy in the nursing profession. Although nursing used the nursing process for different purposes, it was usually nursing that decided and defined what nursing was within the profession. In other words, nursing also learned to develop itself as a profession.

Nursing expanded its view from 'the nurse and the patient' to 'nurses and clients'. This change reflected nursing becoming a 'service' to society more generally. Thus, the sense of individuality in nursing started to move to a group focus as well. It also means that the nursing professionals' sphere reached to the social one. I will explore this further interaction between nursing curriculum and society from the late 1980s to 2007 in the next chapter.

CHAPTER 7 INCLUSIVE CURRICULA?

CURRICULUM DEVELOPMENT
FROM THE LATE 1980S TO 2007

Introduction

The previous chapter discussed how the constitution of curriculum for nurse education has changed and how this change allowed nurses and nurse educators gradually to have control over creating their curriculum. In this sense a curriculum reflects nurse educators' view of nursing and their attitude towards students. However as I showed in Chapter 5, curriculum has its own discursive construction that may amount to its being merely a rhetorical vehicle for ideologies about nursing rather than a way of teaching nursing *per se*. As a conveyance of nursing rhetoric, it contains the core knowledge, teaching practices and subjectivities of learners and teachers. The process from the first voices raised in critique of nursing education within the hospital setting to its re-location and re-focusing as professional education took well over 20 years. As a part of this process, nursing used educational strategies such as thinking tools where problem-solving and the nursing process were used to transform education and practice. These tools were used to shift nursing from 'practice-based knowledge', emphasising repetitive experience as its main 'technique' for learning and teaching, to a curriculum based on process learning and to a professional 'knowledge-based discipline'.

Towards the end of the 1980s, while nurses and nurse educators recognised nursing as a knowledge-based discipline, they also needed to consider social influences such as the number of migrants increased in professional practice and assess the professional qualifications obtained outside of Australia. Nursing education was affected by immigrants required recognition of overseas qualification. The competencies were necessary as a form of assessment of these migrant nurses (see more discussion in Chapter 3, pp. 84-6). This social influence had and impact on regulation of nursing education.

In this chapter, the discourses having an influence on the development of nursing curricula at Flinders University from the later 1980s to 2007 are addressed. The thinking tools of nursing are analysed through a focus on how nursing education and practice utilised them to suit their various political ends.

The curricula between the late 1980s and 2007 is analysed and I categorised them as follows: an interactional curriculum and an inclusive curriculum. 'Interactive curriculum' is defined by its interaction between curriculum design and development and external elements such as socio-economic influences. The inclusive curriculum uses socio-economic developments to feed back into curriculum design and development.

Interactional curriculum: in a wider context

The curriculum developments during this phase interacted with influences increasingly emanating from the wider society. Diagram 17 shows the elements that influenced the curriculum. The curriculum was influenced by social and increasingly by political considerations. In this sense, curriculum design was required to strike a balance between these three influential elements.

Social influence
Competency concept etc.

NBSA guidelines

Curriculum as school's philosophy
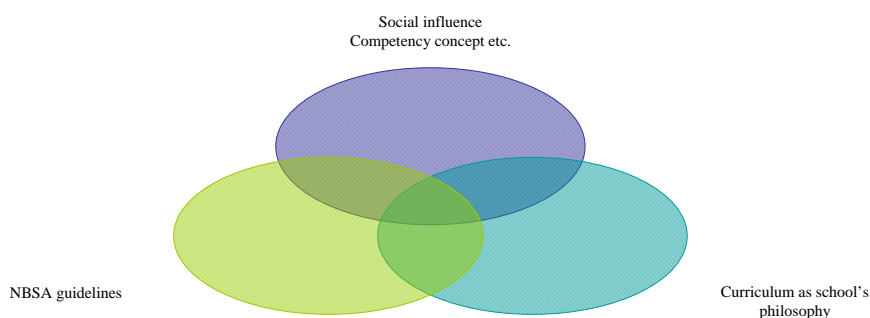
Diagram 17: The components that influenced the curriculum in the 1980s

The category of 'interactional curriculum' means that the curriculum designers were required to interact with authorities such as NBSA, ANCI and nursing schools more

actively and frequently. It means that the curriculum at the nursing school was not only governed at the institutional level. It was also governed at the national level by competency standards, which had a socio-economic context. The emphasis of nursing curriculum was on the credentialing of the profession through an application of competency standards as verification of professional practice and educations (see the discussion between the Nurses Board and nursing academics in Chapter 3, pp. 86-8).

Accompanying this national government demand the nursing profession, the 1980s is significant as the nurse education system was to complete its transition to the tertiary level by the early 1990s. In this atmosphere, a plan for accreditation of the course was submitted to the Board of Advanced Education in 1986. The school background was described (South Australian College of Advanced Education 1987, p. 1) as follows:

> In the 1970s and early 1980s the Commonwealth Government, notwithstanding pressure from the nursing profession and others to do otherwise, had restricted College-based nursing to one program per State. However, in August 1984, the Commonwealth Government decided to accept, in principle, the complete transfer of pre-registration Nursing Education to the Advanced Education Sector, and, therefore, the phasing out of hospital-based programs. It is anticipated that the transfer will be completed in South Australia by 1991.[135]

There was an inclination to restrict the establishment of college-based nursing because this was the first trial. There was some opposition from hospital-based training schools.[136] Nonetheless, Sturt College of Advanced Education proceeded with educational plans for the further development of the nursing profession.[137] Besides the legitimatisation of the nursing profession through the higher education system, the introduction of competency standards was also a socio-economic influence on nursing due to the increase in migrants from overseas. Competency

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[135] Last intake of students were graduated in 1993.

[136] See Chapter 3. The main focus of the transition was how to resolve financial issues.

[137] This is also described in Chapter 3. There was a threat to close the school in 1980. One document explaining this matter was titled: "The Tertiary Education Authority of South Australia decides to close the Sturt CAE as a means of rationalising the College of Advance Education sector in South Australia"(Shoebridge 1996). There was still an opposition to college-based education for nurses.

assessment in professionals became a part of a debate over professional education and outcomes.[138]

Rhetorical meaning of competency and different interpretations

The term 'competency' is used for the first time in the 1986 curriculum documentation. The introduction of this concept to the professional level was controversial during this period (see the arguments of introduction of competency in Chapter 3). How the new concept was introduced and what form this introduction took can be traced through investigating how this term is used in nursing texts. Hence, I describe the term 'competency' as a changeable, contestable and political term. This term can be presented as another rhetorical vehicle for the nursing profession just as it created much uncertainty in its practical application. The term competency is generally defined as 'the quality of being adequate', however, in the nursing profession, the meaning of competency has been interpreted differently. This difference in interpretation of competency exposed the contest surrounding the divergent agenda of the industrial and educational contexts.

In Australia, the idea of competency was introduced and developed with the ANRAC for nursing education and nursing professional entries in the late 1980s. Competency was embedded into the nursing curriculum implicitly and care was taken for it not to have complete control of the curriculum (see argument in Chapter 3, see pp. 86-9). In other words, the nursing competency cannot be measured by a 'check-list' based assessment. If this is the only way, nursing curricula would be strictly task-oriented and objectives-based. As I described competency in Chapters 3 and 6 regarding who governs the professionality of nursing students, NBSA does not interfere in assessing the nursing students' professionality and nurse educators and nurses decide who satisfies nursing professionality.

Since the first appearance of 'competency' in the curriculum course book in 1986 (South Australian College of Advanced Education), the competency concept became

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[138] See the discussion in Chapter 3, pp. 84-8. To be a nurse in Australia required a competency assessment. This competency assessment was available since ANRAC (1990), later ANCI (1998), then ANMC (2006) forming after acceptance by all authorities regarding assessing and transition of nursing registration.

central to discussing behaviour and the abilities of professional nurses. Curriculum, therefore as the bridge between nursing education and nursing practice was strongly influenced by this idea. Moreover, curriculum as the rhetorical vehicle that could contain nursing ideals also contributed to enhancing nursing as a professional group when any curriculum was constructed that used competencies as its validating source. Such a curriculum development then blends the ideals of the nursing profession, none of which are necessarily similar but may be contentious and contradictory. In the next section, I will briefly compare the description of competencies when it first appeared in a curriculum document and in 2002-2007 curriculum, in which the competencies were clearly embedded into the curriculum.

Influence of competency on the curriculum[139]

In this section, I will describe the competency movement's influence on curriculum construction during the 1980s and 1990s. The 1986 curriculum course book described the role and competencies of the nurse for the first time. The competencies referred to the role of the nurse and his/her professional obligations. The course book (South Australian College of Advanced Education 1986, p. 7) describes competencies as part of the explanation of the nurse role. The competencies are composed of seven elements; assessment, planning and intervention, evaluating nursing interaction, interpersonal competence, health and health promotion, maintenance of the rights and safety of the client/patient and management of professional practice. The expectation of the professional nurse is to be able to use the nursing process as this is described in the previous section of competencies (p. 8) and a part of the competencies. However, it is not known how the elements of competencies are embedded into the curriculum to improve the students' professionality as there is no explanation evident.

On the other hand, in the 2002-2007 curriculum guidelines shows the differences in utilising competency in curriculum. The competencies of the professional role became more visible in the descriptions. Competencies are used as objectives and show in which topic students will achieve the competencies. The guidebook explains,

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[139] The external context of competency was also explored by analysis of government documents in Chapter 3, see p. 83.

"The ANCI provides a list of competencies that must be achieved by students on completion of a nursing courses leading to registration (Clare et al. 2001, p. 54)". Thus, the use of competency in Australia started from the professional agenda of legitimating overseas educated nurses and, then, it was utilised in nursing education. Because of the different interpretations of competency, we see contentiousness of it to nurse education and nursing practices (see the discussion in Chapter 3, pp. 86-7). In Australian context, competency is based on the belief that nursing is a knowledge-based discipline and it is not merely to be assessed by a check-list of skills. The ANRAC text (The University of Queensland Assessment & Evaluation Research Unit Education Department 1990, p. 35) shows the complexities of competency assessment and describes the assessment instruments based on the component skills. The instruments for aompetency assessment are given as:

- Multiple choice question tests to measure retention of relevant knowledge
- Multiple choice question tests to measure cognitive skills and knowledge of technical and interpersonal skills
- Problem solving exercises to measure skills in this area
- Observational checklists of skills in the practice setting.

However, the reality gap between this assessment and practice was questioned. The report (Australasian Nurse Registering Authorities Conference 1990, p. 35) described, "The congruency between this conceptualisation of the assessment of a nursing student and the real world of nursing does not appear to be very great" because highly trained and expert nurses do not assess peers by component skills (Maatsch et al. 1987). However the traditional method, which assessed what students were able to do a technique or not, changed to the new approach, which contained various assessment methods such as written tests, observation of clinical practice, structured interviews and analysis of documents used in practice and so on (The University of Queensland Assessment & Evaluation Research Unit Education Department 1990, p. 36). Although the assessment body of nursing competency was transferred from the NBSA to the tertiary education sector, this new approach required collaboration between nurses in practice and nurse educators at the university in terms of assessing the students' professionality.

Expansion of the nursing concept and curriculum

In the previous section, I explored the influence of the idea of competency standards on the design and development of curriculum. The point was that competency standards issued from an influence from the wider society on the nursing profession and was used by the profession as a way to legitimise its professional status. All of that was not without challenge or contest within the profession, yet was used in the political quest of professional recognition. However, it was double edged sword. On the one hand, the competencies allow nurses to proclaim professional status, on the other hand, claiming professional status means that competencies can be used to regulate standards of professional/ individuals.

In this section, I will discuss the nursing concept and philosophy that the nurse educators at SACE and SACAE presented. The table below shows the development of the philosophy of the nursing school. In the 1976 curriculum, the philosophy was not recorded although the concepts of nursing were well described. However, the description is formal and the components of nursing were scattered through the document. Moreover, passive expressions such as 'is acknowledged' and 'this kind' provide a sense of being unsure about how to describe nursing, as well as lacking in confidence to fully state the nature of nursing practice.

Table 5: The description of philosophy in curriculum

The year of curriculum	The description of philosophy in curriculum
1976 Sturt College of Advanced Education	There is no discrete section of philosophy in the course book. However, in the aim of the course, nursing is described as (p. 7): "The combination of care for the sick and education and intervention to provide preventive care for others is acknowledged as appropriate to contemporary nursing. This kind of practice requires skills and knowledge additional to those that have been traditionally acquired within a general nursing curriculum".
1982 South Australian College of Advanced Education	There is a section describing the philosophy underpinning nursing practice. It says: We believe that: Professional nursing involves interacting with people to promote and maintain health, to prevent illness, to lessen the effect of injury, disease or disability, and to facilitate health restoration. Nurses provide care to people as unique individuals in their social, cultural and familial context…

	The concept of health developed by the Alma-Ata declaration in 1978 was embedded in the curriculum.
1986 Diploma of Applied Science at SACAE, Sturt	The course proposal describes (1986, p. 124) the underpinning philosophy as: We believe that professional nursing is an integral part of society's commitment to provide comprehensive and expert health care. The professional nurse is required to function in a variety of settings and roles. The contemporary nurse needs to be prepared for practice in the areas of health promotion, maintenance, and education as well as in the prevention of illness, amelioration of injury, disease or disability and restoration to health… We believe that to prepare the nurse to manage rapid technological and social change, and to respond appropriately to increasing ethical and legal demands, a broad knowledge base is necessary…An eclectic approach to the study of the discipline of nursing within the program encourages students to be thoughtful and analytic in their approach to care. They are required to **solve problems** and to seek original solutions to unique human situations. We believe that <u>the client</u> is the focus of nursing, and is an integral member of the health team… We believe that the process of learning is enhanced through the planned and sequenced stages of the course…

During the 1980s curriculum started to articulate a philosophy of professional nursing. In the 1982 curriculum, the statement uses 'we' for the first time, implying that nurse educators' were willing to cite and defend their beliefs from a deep understanding of nursing with the contextualisation of 'health'. It was also influence from the Alma-Ata declaration that nursing's caring role of the sick was expanded. The emphasis of nursing was still on the health care provider role but there was no description of professional nurses.

On the other hand, the 1986 curriculum made remarkable changes in terms of the role descriptions of nurses. The role of nurse had been clearly described by the NHMRC in 1983 and it highlighted the expansion of the role (see Chapter 3, p. 79). The statement is a more confident than those already explored from previous periods. It is more like a claim of professional status than a set of beliefs about approaches to nursing practice. The curriculum also refers to the NHMRC definition and it has significance for indicating influence at the national level in regard to the curriculum.

Legitimating the expanded role of nurses meant changing traditional views of what should be learnt by nursing students.

Different terms were used in the curriculum and demonstrate the ownership of beliefs in the profession. Four sentences use 'we believe' and this implies that the curriculum designers had clear beliefs about nursing. After the Alma-Ata declaration in 1978, its influence in terms of defining 'health' grew. Descriptions of the role of nurses emphasised their function in society. The second and last statements are about the perspectives of the nurse educators. The statements looked at the requirements for nurses and how they could achieve nursing professionality. Moreover, the process of learning and how the nursing students could achieve was described. The emphasis on the students' learning indicates a focus on the students' perspective and needs. I have discussed this perspective in Chapter 5. Seeing curriculum as a process, the focus in development of professionality is included in the curriculum and learning sees as students' responsibility, as part of their professional development. Thus, the shift in the meaning of curriculum is evident and 'the process of learning' was becoming the essential perspective in nursing education.

Nursing as 'service'

The statements in the 1986 curriculum use the term 'client'. 'Client' is used if there is a relationship between consumers as individuals and suppliers to satisfy their demand through purchasing goods and services in a market. In a nursing context, 'demand' will be clients' (as patients) needs and patients will 'purchase' goods and services from nurses by being provided care from nurses. In this sense, nursing care is 'goods and service', which was previously thought of as nurses' dedication and virtue, that cannot be valued. In this context, the work of nurses is calculated and marketed. Hence, establishing the sense of consumerism of nursing meant that 'nursing' became accepted as a form of service in Australian society and not as an individual's vocation. The definition of an RN by ANRAC as discussed in Chapter 3 includes the term 'client' and it says that the RN role includes 'client advocate'. Thus, curriculum was influenced by the socio-economic definition of nurses and this influence continued to affect nurse education and practice when competencies were introduced in nursing in more recent years.

Nicholson (1998, p. 138) highlighted four points in the changes in the Flinders 1980s curriculum documents, and also provides evidence of external influences on the curriculum. The first point she notes is a reduction in training time for nursing students. The second point is, "nursing in the curriculum was extended to incorporate more abstract theoretical notions such as holism" (p. 138). The second point also leads to the third point, "the integrative approach to nursing". The last Nicholson notes is: "Finally, the psycho-social strand was re-designed to support the theory and practice of nursing" (Nicholson 1998, p. 139). Indeed, the integrated approach to nursing education began by implementing the various perspectives of nursing including professional nursing as a form of social commitment. The role of nurse in the social sphere was reflected in the nursing curriculum and it also triggered a deeper interaction with use of sociological knowledge in curriculum. This is also part of the process of its utilisation in the professionalisation agenda as discussed in Chapter 2.

In this atmosphere, it was not only external influences such as the competency movement and sociological knowledge development that shaped nursing curriculum, but also internal influences that were significant in implementing the thinking tools such as 'problem-solving process', the nursing process and so on (see Table 6 in next page). As I showed in Chapter 5 the discourses on thinking tools for nursing, were used as a part of a means to distinguish nursing from other disciplines and produced different interpretations of nursing at the same time. The different interpretations created the two streams of the nursing process; one was about interacting of patients and nurses, the other was a systematised way of doing nursing. Both nursing process discourses aimed to separate nursing from medicine and to establish a professional discipline. How then was nursing represented in the 1980s curriculum? Table 6 in next page shows how the terms 'problem-solving' and 'nursing process' were used in these curricula.

The terms 'problem-solving' and 'nursing process' in the 1980s' curriculum

Table 6: 'Problem-solving' and 'nursing process' as used in the 1980s curriculum

1982	The reaccreditation booklet for the course Diploma of Applied Science Nursing (p. 28)	describes that the year one students will be able to …demonstrate an understanding of the **nursing process** utilising the skills of **problem solving** to plan specific care for individual…
1985	The report of the development of basic nurse education at the college (1985b)	The nursing students' programme outcome in the early stage contains: …use **problem-solving skills** in assessing, planning, implementing and evaluating nursing intervention…
1985	The expectations of The Nurses Board of South Australia in relation to Higher Education Courses (1985a)	shows they expect outcomes of the course of studies: …use a **problem-solving process** in patient/client care aimed toward health promotion
1987	In the curriculum guide by the Nurses Board of South Australia	stated that the three major competencies areas relating to practice role for nursing: Nursing practice and the client/ patient; Nursing – the profession; The student as a person. The guide explains Competencies related to the practice role indicate that the nurse possesses sound **problem solving** ability, thus **the technique of problem solving** is to be integrated thoroughly within the entire programme. For effective **problem solving** to take place sufficient foundation knowledge must be taught as the basis for assessment.
1987	Re-accreditation of the Diploma of Applied Science at the South Australian College of Advance Education	The **concept of problem solving** appeared in the category of competencies categories such as assessment, planning and intervention and is describes as follows (p. 8): Assessment is the basic competency and is fundamental to nursing practice. The development of assessment skills and their application to a variety of health, health promotion and care of health settings involves a complexity of knowledge, skills and attributions such as observation, monitoring, data collection, intuition, **problem-solving** – and ultimately judgement and decision making…Like assessment, planning and intervention is a nursing competency of fundamental importance. This competency

<table>
<tr><td></td><td></td><td>involves a problem-solving approach to the planning of individual care.

There is a one topic using the term of Nursing Process in the content of topic called 'Activities of living with nursing support' (p. 157). It says;

The content of this section includes the Problem Solving Process applied to the care of the person with dysfunction…The Nursing Process is introduced, and applied in the clinical field. The concepts of disability, impairment and handicap are explored as are primary, secondary and tertiary health intervention.</td></tr>
</table>

I note though that the ability of 'problem-solving' is more emphasised than 'nursing process' in the 1980s curriculum. The expression 'applied in the clinical field' means that nursing process was more used as a bridging device for problem-solving into the clinical setting. The term 'nursing process' was still not commonly used in the curriculum (although the meeting at the school indicates the introduction of nursing process as it is to be used in the class) (see Chapter 6, p. 183). This appears to signify a resistance by staff, to a formulaic application of 'nursing process'. There was an attempt to show that by application of the steps, that 'the process' was individualised.

In the 1982 and 1985 curriculum, the term 'problem-solving' was described as students being expected to use this as a nursing strategy. According to Price (2000, pp. 112-3), "problem-solving' skills contain the assumptions to be able to make decisions by nurses basing on their knowledge and experiences". In gaining this skill it is believed that the students would be able to make judgements. This is an emphasis in utilising the skill rather than gaining knowledge and experience and this way of assessing the professionality has similarity in the traditional way of assessments (for example, 'check-list' type of assessment) as I described previously (see pp. 196-7).

In the 1987 re-accreditation curriculum, the way of describing competencies has slightly changed from the previous 1982 and 1985 curriculum. It was described as a set of broader competencies rather set of skills. However, the elements of assessing

competency relies on the seven elements: "assessment, planning and intervention, evaluating nursing interaction, interpersonal competence, health and health promotion, maintenance of the rights and safety of the client/patient, management of professional practice" (South Australian College of Advanced Education 1987, pp. 8-9). The problem-solving approach was part of the competency elements of 'planning and evaluation', and problem-solving is described as the necessary approach to fulfil 'planning and evaluation'. Although the emphasis is not on gaining skills, it states: "It [problem solving] also involves the development of clinical nursing skills and their application in the delivery of care – physiological and psycho-social". Analysis of the way to use 'problem-solving' and 'the nursing process' in curriculum shows that these tools used to promote nurses' practice based on their autonomous activities.

Judgement and decision-making in the curriculum – the emergence of 'autonomy'

I discovered new terms such as 'judgement' and 'decision-making' used during the phase of the 'interacting curriculum' in the 1980s. In Table 6 (see p. 202), some of the nurses' attributions are indicated, "…health settings involves a complexity of knowledge, skills and attributions such as observation, monitoring, data collection, intuition, problem-solving – and ultimately judgement and decision making…" in the 1987 curriculum.

Comparing to the 1970s curriculum (see Chapter 6, p. 180), I mentioned that the descriptions implying the terms such as accountability and responsibility were used. Professionality descriptions in the curriculum became more visible and the terms to describe them are explored. What this explains is that the context of the nursing professional has developed and is now embedded into the curriculum. For example, the nurse can act on what he/she observes with their knowledge, which heralds the appearance of autonomy in this case. As I discussed previously in this chapter (see p. 181) autonomy begun to be used in nursing discourses in the late 1980s and the curriculum was also influenced by this new attitude to professional legitimisation. While the approaches such as problem-solving approach and nursing process were treated as essential tools in the curriculum, these were also bridging tools to nurses claiming autonomous practice.

In this atmosphere, the appearance of 'decision-making' can be understood in terms of Foucault's thinking (see Chapter 1, pp. 8-9). This process concerned nursing as a discipline gaining authority to actively manipulate and apply nursing knowledge to obtain legitimacy and validation of its expertise. Recognising problems and knowing 'what' this means for practice shows there was a 'power shift' in the nursing profession.

Towards an inclusive curriculum

This inclusive phase of curriculum design and development focused more on interactions between the external and internal influences on the nursing profession. The curriculum during this period was characterised by synergy between these influences, and this in turn changed the position of the nursing profession. As the roles of nurses became more varied through the 1990s the development of nursing knowledge led to improvements in the curriculum such as development and design becoming more inclusive of stakeholders. Diagram 18 in next page shows how the curriculum is influenced by four elements. Compared to the earlier diagram, industrial and socio-economical elements have been added. For example, curriculum is influenced by teaching staff allocations on campus and in nursing practice. These influences impact not only on the quality of learning of nursing students in practice, but also the quality of learning of nursing students on campus.[140] However, one of the purported motivations for establishing nurse education in the tertiary sector was the idea of increasing a sense of autonomy in the nursing profession and it is how curricula have used concepts to increase this possibility to which I now turn.

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[140] This is also due to the increase in nursing students in recent years. According to the curriculum document (Flinders University of South Australia School of Nursing and Midwifery 2006, p. 14), "Approximately 50 academic staff and 23 administrative staff care for the learning needs of over 1500 students".
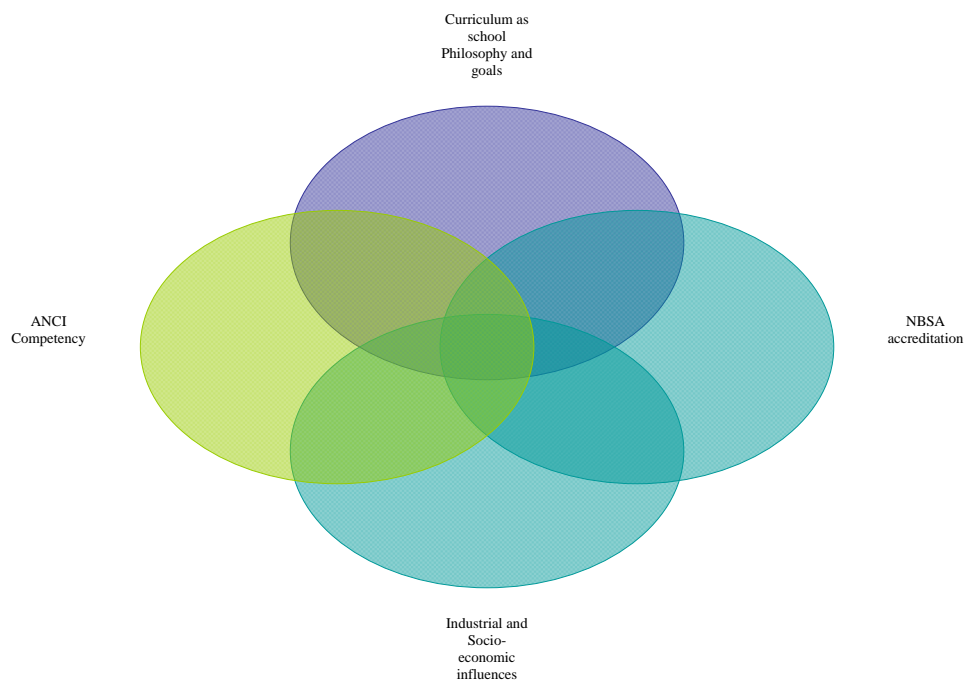
Diagram 18: **The influential components of curriculum formation between the 1990s to 2007.**

Local knowledge as an explicit nursing philosophy

I retrieved the school philosophy from the curriculum and investigated how nursing was expressed in this form of writing (see Table 7, p. 211). Describing the philosophy in the past curriculum can reflect the changes in ideas how the personal and local knowledge in nursing became universal knowledge. For example, the 1990s curriculum shows a more concrete philosophy of nursing for the school. The description of philosophy is more explicit and the school states what its education is based on. The 1992 curriculum philosophy demonstrates that nursing is conceived of as a discipline with its own knowledge base. The curricula in 2002 and 2007 simplified the explanation of the nursing school's philosophy. This philosophy of nursing shows the sharing of ideas in nursing. It can also be described as a 'black box' (described in a later section). Latour (1987, p. 216) showed how inside of the 'box' can be explained through the story of a LaPerouse' exploration, who was a captain of the ship when there was no scientific instrument such as satellites:

> In less than three centuries of travels such as this one, the nascent science of geography has gathered more knowledge about the shape of the world than had come in millennia. The *implicit* geography of the natives is made *explicit* by geographers; the *local* knowledge of the savages becomes the *universal* knowledge of the cartographers; the fuzzy, approximate and ungrounded *beliefs* of the locals are turned into a precise, certain and justified *knowledge*.

In nursing context, women who took on the care of the sick, some of whom were religious women[141] had local, implicit knowledge. Gaining the bigger picture of knowledge in nursing by both subordinating and importing other disciplines in the past, it came to be a universal knowledge.[142]

Thus, philosophy in the nurse education curriculum contains the process of nursing knowledge becoming universal knowledge, which is assumed to be a 'discipline' in the Latour's context. However, in its rhetorical function curriculum started to represent taken-for-granted and complex concepts that required little explanation in nursing. The curriculum as one such black box becomes only a place for inputs and outputs, and once again the processes through which its inputs turn into outputs becomes shrouded in mystery or so 'known' to everyone that its processes are taken-for-granted – so accounts of the nursing process in the nursing philosophy are no longer required.

Through this retrieval process I found that there were three noticeable changes in the 1992 curriculum philosophy. Firstly, the 1992 philosophy centred on health and a different perspective towards the person – a holistic view – is added. In the previous curriculum of the late 1980s, there was a concept of health where the emphasis was on providing individualised care. However, the 1992 curriculum shows more depth of meaning in the view of health as physical, psychological, spiritual and social. Secondly, an emphasis on the caring role of nurses in the 1990s is seen rather than an emphasis on the varieties of nursing roles as exemplified in the 1986 curriculum. Finally, there are clear statements showing of what nursing knowledge consisted of. The 1992 curriculum covers all perspectives from the definition of health following the Alma-Ata declaration in 1978, statements issued by the Commonwealth

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[141] See this description in Chapter 2, p. 34.

[142] I explored the process of knowledge subordination by analysing how the thinking tools was talked about and discussed in Chapter 4 as part of nursing professionalisation.

Government in the 1980s and the components of nursing knowledge. In other words, its philosophy satisfied the external and internal spheres of the nursing profession.

On the other hand, I found different attitudes towards the nursing curriculum between 1992 and 1997. The 1997 curriculum's philosophy is about how the nursing school functions rather than the school's philosophy about nursing. Although the attributes of the graduates are clearly stated, there is no description of school philosophy about nursing. In this sense, the emphasis of nursing education was on external factors interacting with nursing to achieve students' competencies.

Rationalised concepts in the curriculum

The words in the curriculum changed and this differentiated each new concept. In the 2002 curriculum, the description of philosophy became a simple expression of 'people', 'nursing', 'the body', 'health' and 'the environment' (see Table 7, p. 211). The curriculum as a black box contains these nursing core concepts as inputs and the process of how these become a nurse is taken-for-granted. [143] The formation of core concepts of nursing lies in the Foucault's formation of concepts (1972, p. 63):

> In order to analyse the rules for the formation of objects, one must neither, as we have seen, embody them in things, nor relate them to the domain of words; in order to analyse the formation of enunciative types, one must relate them neither to the knowing subject, nor to a psychological individuality. Similarly, to analyse the formation of concepts, one must relate them neither to the horizon of *ideality*, nor to the empirical progress of *ideas*.

The rules of how objects (professional nurses) of a discourse are formed do not lie in the objects themselves or words used to describe them, rather they lie in how the objects are spoken of or thought about it. In other words, how professional nurses are described is not the only meaning for nursing. For example, the role of nurses in the 1990s that I discussed in Chapter 3 are, "caring, counselling, co-ordinating, client advocate, professional development, consultant and academic/educator and researcher roles" (NHMRC 1991, p. 1). As I described the term use 'client', it implies nursing is recognised as a service (see p. 200). The term 'academic' implies

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[143] These 'taken-for-granted' concepts here highly contested in the late 1980s and 90s with little agreement about their meaning amongst theorists (Meleis 1997, p. 45)

that nursing becomes one of many disciplines. These roles of a nurse are not only ways to be a nurse and there are discourses making these roles explicit. Moreover the autonomous professional identity lies in how a position is put, how it persuades and forms subjectivity and is used to form the objects of which they speak. There is another example. The thinking tools such as nursing process, problem solving and clinical reasoning were emphasised as attributes of a skilled professional nurse. The emphasis on these skills, means the description of a professional nurse is interpreted such that a nurse needs to obtain these skills. Although there is no record showing how these concepts in curriculum were formed, the key words in nursing schools' philosophies about nursing education acted as synonyms used to describe nursing.

In contrast to the 2002 curriculum, the 2007 curriculum was more explicit about its version of philosophy/beliefs and the key words of the nursing school's philosophies were described. In-depth definitions of key words such as 'professionalism', 'nursing care' and 'inquiry', are provided. This is due to a different approach to the curriculum development and of nurse educators toward teaching at the school.[144] In the definition of professional nursing, differences in nurse roles emerged (Flinders University of South Australia School of Nursing and Midwifery 2006):

> The professional nurse is a reflective practitioner who is responsible and accountable for practice; contributes to political debate on health and health care policy and the development of the role of the nurse and nursing knowledge.

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[144] The School of Nursing from its inception at Sturt prided itself on not having to rely on service teaching. It was/is one of very few Schools in that situation in Australia. It was argued that with biological and social scientists as members of the School, that the curriculum would be more likely to meet the specific needs of nursing students. Whenever possible nurses with dual qualifications were appointed, i.e., nurse scientists and nurse sociologists. This was not always possible but many non-nurses committed themselves to the school over the years and made health and nursing their area of scholarship. In 2002 a highly integrated curriculum model was implemented. Most topics were nursing topics and the biological and social sciences subsumed into nursing topics. The School's own evaluation of this model was that students had more difficulty in applying core concepts of the foundation disciplines such as sociology and psychology to nursing and that teaching of these disciplines was more 'patchy' than it had been in discipline specific topics. The 2006 curriculum returned to teaching discipline specific topics, for example in sociology and psychology, while retaining some of the teaching and learning strategies developed for the 2002 curriculum (J Condon, 2007, pers. comm., 26 November).

Professional nurses were concerned with their role as health advocates. This role was not only decided by society, but between society and nursing professionals. This explanation places such statements into the categorisation of 'collaborative curriculum' in that the nursing profession was created and formed by influences from both the wider society and inside the nursing profession. Hence, when comparing the 1970s and 1980s statements, these show that creating the nurse role was the nursing professionals' responsibility. Furthermore, the concept of 'inquiry' became part of the 2007 curriculum. Terms such as 'evidence', 'clinical reasoning' and 'critical thinking' were named and were emphasised as a part of what could be termed professional nursing.

Changes in 'the thinking tool' for nursing

From 1992, the curriculum texts contained more cognitive elements such as reflective practice, clinical reasoning and problem-framing, which became more explicitly expressed in each curriculum to 2007. These cognitive processes in the nursing profession suggest that nursing has become a more autonomous profession able to manage the situations that nurses find themselves in by thinking and applying knowledge to the situation. For example, in the 1992 course proposal, the registered nurse and the philosophical statements were clearly described (Flinders University of South Australia School of Nursing 1992). The profile of the registered nurse also shows that the competency of the registered nurse was standardised by ANRAC (see Chapter 3). As discussed in Chapter 3 and Chapter 6 in terms of attitudes toward the competency standards, how the concept of competency was implemented into nurse education proved to be contested and controversial. In the course proposal, objectives were guided by ANRAC-based competencies: "They also recognise that nurse education should reflect the need for nurses to be independent thinkers and decision makers who are able to cope with ongoing change" (Australasian Nurse Registering Authorities Conference 1990, p. 24). The components of competency are clearly stated in the course objectives and the definition of nursing shown in the course proposal. Nursing is expressed as having two aspects in the 1992 curriculum (Flinders University of South Australia School of Nursing 1992, p. 29):

> (i) **clinical reasoning** and reflective practice based on nursing science and art and the supporting sciences and general studies;
> (ii) **professional** studies focussing on nursing knowledge, research and **role development**.

These descriptions of nursing also show that nurses are expected to be independent in their cognitive activities. In other words, nurses are expected to utilise their thinking tools for their own professional decision-making in practice and to further their professional development. 'Clinical reasoning' was still thought of primarily as a tool rather than a means of developing nursing knowledge. 'Clinical reasoning' is presented as a cognitive process within the nursing profession which has introduced new aspects to nursing (discussed in the next section). Moreover, there is a focus on professional studies as a means to explore nursing knowledge and research. This description illustrates the school's philosophy of the nursing profession and how nurse educators plan to teach nursing knowledge as a part of professional education. In the 2007 curriculum, professionalism was defined and 'clinical reasoning' becomes embedded in professional nursing. There is no emphasis on acquiring this skill (see Table 7 below).

Table 7: Nursing philosophy in the 1990s curriculum

Year of curriculum	The description of philosophy in the curriculum
1992 Bachelor of Nursing Practice and Bachelor of Nursing Course proposal (Flinders University of South Australia School of Nursing 1992)	The course proposal described the philosophical statements as follows: The courses is [sic] based on the following beliefs about nursing: 1) the central focus of nursing is health which involves the whole person – physically, psychologically, spiritually and socially; 2) health and illness are influenced by social and cultural history and life circumstances; 3) the focus on health is primarily a focus on caring rather than on curing and is concerned about development, promotion, maintenance and optimising of health at whatever level the person is capable; 4) the caring role of the nurse includes advocacy and provision of choice for clients and encouraging and empowering people to take responsibility for their own health; 5) nursing is a practice discipline and that improvement of practice emerges primarily out of praxis, reflection-in-action; 6) the knowledge base of nursing is at least fourfold, including empirical scientific knowledge, expressive knowledge (nursing art), personal knowledge and moral knowledge.
1997	The curriculum document of 1997 (p. 2) describes **the aim** of the course

Bachelor of Nursing (Flinders University of South Australia School of Nursing 1997)	as: Prepare women and men for 'beginning level practice as registered nurses' who: -are reflective about practice and have well developed clinical reasoning skills; -understand that professional practice demands life long learning; -are eligible for registration with the Nurses' Boards of South Australia as Council Inc (ANCI) Competencies; -have well developed generic knowledge based skills in accessing information, written and oral communication; -understand how social, environmental and economic factors impact on health; and -are able to negotiate with those who have different interests and understand culture differences and their relationship to health.
1997 The letter to the NBSA dated 3 February 1998 (Flinders University of South Australia School of Nursing 1998)	It is written regarding the matter of changes in the 1997curriculum: "…There has not been a new curriculum development written as result of the Review but the recommendations of the Review have been incorporated into the curriculum based on the 1991 Curriculum Document…As discussed with you the review of the Bachelor of Nursing was not undertaken with your current standards as a guide. Therefore, we would like your panel members to take this into account".
2001 Bachelor of Nursing (Clare et al. 2001)	Philosophy guiding the curriculum (p. 21) In the curriculum proposal, it is written: "The Bachelor of Nursing curriculum is guided by the following accepted central tenets of professional nursing: **people**, **nursing**, **the body**, **health** and **the environment**…"
2006 Bachelor of Nursing (Flinders University of South Australia School of Nursing and Midwifery 2006)	In the curriculum proposal (p. 26), the philosophy supporting the course is described as **professionalism**, **nursing care** and **inquiry**. Professionalism is defined as (p. 26): ▪ Professional nursing is person – centred, negotiated with the person, family or community based on the recognition that people are self-determining ▪ Professional nursing is based on clinical reasoning, taking account of the political, social, cultural, psychological, legal and ethical contexts of care and the best available evidence. ▪ Nursing is collaborative and contributes to decision making and care, as part of the health care team. ▪ The professional nurse is a reflective practitioner who is responsible and accountable for practice; contributes political debate on health and health care policy and the development of the role of the nurse and nursing knowledge. Nursing care is defined as: ▪ Nursing care is based on the primary health care principles of

access, justice, self-determination and equity and focuses on prevention of illness, health promotion, providing continuity of care and aims to optimize health for people at any stage of the health-illness trajectory.

- Health is impacted on by a dynamic interplay of physical, social, cultural and psychological factors and nurses takes these factors into account in assessing, planning implementing and evaluating care and its outcomes.
- Nurses are safe and therapeutic practitioners whose central objective is caring. Underpinning caring is the ability to *grasp the meaning* of situations*; make a meaningful connection* with the other; and perform skillfully, based on nursing knowledge and ethical principles. (Johnson, 1994). Grasping meaning, making a meaningful connection with another and skilful performance require an understanding of the embodied nature of people and the interaction between mind, body and spirit.

Inquiry is defined as:

- Nursing is both an academic and a practice discipline. There is a reflexive relationship between practice, research and theory and reflexive and reflective nurses develop nursing knowledge for better patient outcomes.
- Clinical reasoning is based on critical thinking and evidence. Nurses have an inquiry based attitude towards practice and are able to provide justifiable rationales for practice.
- Nurses recognize the ambiguity of the practice arena and are resourceful in problem setting and problem solving.

What is behind the use of tools in curriculum?

Investigation of the relationship between nursing concepts and the curriculum is also the part of the process of the internal forms of control over uncertainty for the nursing profession. It is my contention that the use of thinking tools for nursing represents its internal control over uncertainty and has had a strong emphasis on the curricula since the 1992 model. In the course proposals, the term 'problem-solving' is used less frequently in the 1990s. Until the course proposal in 1990, the term 'clinical reasoning' had not been used and the emphasis was on applying a problem-solving approach. In 1992, the course proposal introduced clinical reasoning for the first time.[145] The emphasis on cultivating clinical reasoning in nursing students is described (Flinders University of South Australia School of Nursing 1992, p. 33) as follows:

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[145] The term 'decision making' refers to the concept of autonomy used in the 1987 curriculum. See also p. 202.

> …This has led to the conviction of clinical teachers, that the focus of the clinical placement must be on student learning with an emphasis on clinical reasoning, rather than on assessment purely of skills, as has been a major emphasis in the past.

Nursing in the proposal is conceptualised as the application of "clinical reasoning and reflective practice based on nursing science and art". From such a point of view, student learning is not limited to processes that seek a 'known-answer' to problems by applying a problem-solving approach. The argument is put in the document that such an approach would be to merely mimic a medical approach to clinical practice. The reasons given for such an approach are interesting in that a focus on a 'nursing' problem solving approach does not provide sufficient scope for developing nursing knowledge from clinical practice. What is also interesting is that in using the term clinical, the development of a unique form of knowledge has now been transformed. However, in the 1992 course proposal, clinical reasoning was not clearly defined or described. It is clear that this concept was not clarified for some time as according to Higgs and Jones (2000, p. 11), clinical reasoning is "a process in which the clinician, interacting with significant others, (client, caregivers, health care team members) structures meaning, goals and health management strategies based on clinical data, client choices, and professional judgement and knowledge".

Clearly the curriculum development at Flinders preceded such clear definitional work. Reasoning was explained as the thinking process that judged or decided so clinical reasoning was viewed as a process on which nurses make judgements based on their knowledge and experience. How were these cognitive tools of nursing implemented in the curriculum and how did they collaborate with the nursing curriculum? The actual method of using 'clinical reasoning' and 'problem-solving' will be discussed in the next section.

Problem-solving approach and clinical reasoning from the 1990s to the 2007 curriculum

The sentences using the terms 'problem-solving approach', 'clinical reasoning' and 'nursing process' were retrieved from the curriculum. Table 8 on next page shows significant changes in how the thinking tools were operating.

Table 8: 'Problem-solving' and 'nursing process' in the curriculum

Year	Curriculum	The sentences using the terms 'problem-solving' and 'nursing process'
1990	Re-accreditation of the Bachelor of Nursing at South Australian College of Advanced Education	No explicit use of term 'nursing process' and 'problem solving'
1990	Re-accreditation of the Bachelor of Nursing at South Australian College of Advanced Education	In the topic of 'Nurses and their environments', one of the objectives contains problem-solving.
1990	Re-accreditation of the Bachelor of Nursing at South Australian College of Advanced Education	In the topic 'Professional nursing studies', three themes are shown. One includes philosophical, ethical and legal perspectives. It says: This section will review personal, social and philosophical constructs associated with nursing and health care...and question the various **problem solving** and decision making approaches to ethical dilemmas and legal issues in nursing.
1990	Re-accreditation of the Bachelor of Nursing at South Australian College of Advanced Education	The topic is called 'problem solving'. The topic objectives are (p. 42): 1. develop **problem-solving** and decision-making skills relevant to nursing practice; 2. demonstrate creative and effective thinking skills applied to **problem-solving** and decision-making strategies; 3. generate a range of planning strategies for use in any situation related to nursing practice
1992	Bachelor of Nursing course proposal at Flinders University, School of Nursing	There is no term 'nursing process'. One of the course objectives based on the ANRAC Competencies for Registration as a Nurse (1990) states that on the completion of the course students will be conversant with: **Problem solvin**g and clinical reasoning – approach **problem solving** in a manner which recognises that not all problems have known solutions.
1992	Bachelor of Nursing course proposal at Flinders University, School of Nursing	The definition of nursing in the course proposal booklet, is described as follows: Nursing consists of two closely related aspects ….One is clinical reasoning and reflective

		practice based on nursing science and art and the supporting sciences and general studies. Also included is: professional studies focussing nursing knowledge, research and role development.
1992	Bachelor of Nursing course proposal at Flinders University, School of Nursing	In the section on psychosocial science, the proposal states: It is recognised that it is not possible to anticipate all the knowledge and skills a professional nurse will require to deal with the problems they will meet. Therefore this strand also intends to contribute to the development of the students problem posing, **problem solving** capacities and encourage them to be independent learners…(ANRAC competencies, 1990)
1992	Bachelor of Nursing course proposal at Flinders University, School of Nursing	In the section on approaches to teaching, learning and evaluation, **problem-solving** is referred to: A number of beliefs have underpinned the thinking about student learning in the curriculum…. that independence in problem framing and solving and in inquiry be nurtured in classroom and practice….
2002-2007	Bachelor of Nursing Curriculum at Flinders University, School of Nursing and Midwifery (accredited by NBSA in 2001 November)	No term for 'nursing process' is evident. However, there are topics using 'clinical reasoning'. the terms are used in the aims of the topic and described (Clare et al. 2001, pp. 36-7): Provide support for **clinical reasoning** with the fundamentals of microbiology, immunology, pathophysiology, pharmacology, ethics and social theory relevant to nursing practice. In the syllabus section (p. 37): This topic facilitates the student in the development of knowledge, skills and confidence for safe, caring and efficient nursing interventions, using **clinical reasoning** and functional health patterns to develop acute nursing skills. In the aims of a 3rd year nursing topic: On completion of this topic students will be able to: apply a **clinical reasoning** approach to the assessment, provision and evaluation of integrated nursing care…

2007-2011	Bachelor of Nursing Curriculum at Flinders University, School of Nursing and Midwifery (accredited by NBSA in 2007)	Problem-solving approach: There is no topic that the term 'problem solving approach' used in the topic title. However, the term is used in the aims of topics and 'problem based learning' is described as the one of the teaching strategies used in topics.

As I wrote earlier when comparing the 1970s and the 1980s curriculum (see discussion p.186 and pp. 202-3), the former decade concerned task-oriented nursing duties whereas the latter decade (the discussion in pp. 202-4) demonstrated an emphasis on patient-centred care. In the discussion about the nursing process in Chapter 4, I argue that applying the nursing process in a prescriptive way risks impeding nurses' critical thinking (see Chapter 4, pp. 118-119). Nurse educators had many concerns about fitting nursing into the nursing process and problem solving framework. Also this resistance is evident in the writing of curricula where there is evidence that no topic included the term using 'nursing process' either in the topic title or topic outline. The term 'problem-solving' approach is more frequently seen up to 1992 and then the term is used in tandem with 'clinical reasoning' and 'decision-making'. This indicates that the influence of competency interpretation into curriculum has been changed over time from implicit to explicit and the concept of competency is understood in broader meaning. Furthermore, the description of professionality has greater variety while uncertainty in the profession status has decreased by detailing and broadening the nurse role from individual sphere into social sphere. On the contrary, nursing description, for example, the thinking tool of nursing become inclusive of other disciplines and the change in the thinking tool is seen. In the next section, I will examine how the thinking tool become inclusive and the term nursing used less in the thinking tools.

Nursing vanishing from the tools?

The thinking tools focus more on the situation than the general discipline so that the term 'nursing' then vanished from both the definition of a thinking tool of nursing. The introduction of 'clinical reasoning' and 'decision-making' thinking tools indicates the influence from other disciplines such as cognitive psychology and medicine. The term 'clinical' also shows that reasoning applies to all clinical themes and not only those in the nursing discipline. Clinical reasoning is a process that

identifies problems and how professionals nurses handle them. Unlike the nursing process, clinical reasoning aims to avoid generalisation of nursing practices by focusing on individual patient's situations. Moreover, the thinking process in clinical reasoning applied to all situations and all clinical or practice settings. Although clinical reasoning and decision-making are often discussed together, McAllister and Ross (2000, p. 205) clearly distinguish between clinical decision-making and clinical reasoning:

> We see clinical decision making as an end-product of clinical reasoning; the generation of tangible decisions about clinical management. In contrast we see clinical reasoning as the often intangible, rarely explicated thought processes that lead to the clinical decisions we make.

Although there are several ways to define clinical reasoning, the term used in the 1992 curriculum defined clinical reasoning as a cognitive aspect of the role of the nursing professional (see p. 210). It focuses on a particular view of practice underpinned by certain assumptions. 'Clinical reasoning' and 'problem-solving' were used as objectives in topics and moreover teaching strategies after 1992. This means that the thinking tools such as clinical reasoning and problem solving are not only considered as the main objective for nursing students. In some sense, the thinking tools shifted from nursing students' technique to nurse educators' tools to cultivate the clinical ability of nursing students. There is no clear evidence of the reason for using this term in teaching strategies, however, as I discussed in Chapter 5, in terms of curriculum as praxis, the curriculum is to be seen as inclusive and this approach aims for learners to recognise their learning processes (see Chapter 5, pp. 146-7).

Black box curriculum

The curriculum needed to satisfy the complexities that existed in the context of regulation of nursing practice and education by competency standards. The curriculum used more concepts of nursing such as 'health', 'professionalism' and so on (see this discussion in p. 212) instead of spelling out these complexities, thus the term 'nursing' disappeared from topics in the curriculum. In this atmosphere, curriculum turned into a 'black box'. Latour (1987, p. 3) used the metaphor of a 'black box' as follows:

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> …is used by cyberneticians whenever a piece of machinery or a set
> of commands is too complex. In this place they draw a little box
> about which they need to know nothing but its input and output…

In this case, the little box as described here is an 'un-known process' or a taken-for-granted area. In the curriculum sense, the box may contain the processes to educate a professional nurse. The educators suggest what they need to learn to be a professional nurse and seek what is the best way to do this. The nurse educators use the thinking tools such as the nursing process, problem-solving approach and clinical reasoning and so on to maximise the students' learning. For example, the nursing process was used up to the 1980s curriculum (see Table 6) and later this became the 'problem-solving' approach and 'clinical reasoning' were used. With this change, the term 'nursing' vanished as a description for thee tools.

While something is happening in the process, we do not know what the output will be. When we do know, we can reflect on what was in the black box. In other words, the complicated and complex process requires much working out, however once we know what we know what will happen through a process, we skip outlining what the process actually is. I will show another example. What the nursing process brought was rationalisation of nursing for management of care, while losing the individualised perspective in the institutions. The curriculum has black boxed the use of nursing process as I have analysed over time. The thinking tools such as the nursing process, problem-solving approach were utilised in the curriculum but their manner of appearance changed over time.

Latour (1987, p. 242) describes that the outcomes of such a practice of human endeavour may appear as a 'miracle'. He gives the following example:

> indeed to see a clover-leaf intersection fitting *precisely* with the
> freeways whose flow it redistributes!...They are so enthralled by
> this mystery that they are fond of saying, 'The least
> understandable thing in the world is that the world is
> understandable.

Were the nursing thinking tools a miracle of nursing? Did they make it explicit what nurses needed to do as a process? Is nursing seeking a way to fit with the tools? As I have discussed through Chapter 4 to 6, how the thinking tools can shape and

influence on nursing in terms of curriculum, nurses and nurse educators, do nurse always look their boxes? If nurses only seek for the way to fit or what to be fitted, the uniqueness of nursing will be lost and will be only the copy of other disciplines.[146]

Implication of change from invisible tools to visible tools

Nursing became visible by legitimating its position and status as a profession. It is the argument of this thesis that the nursing process was a springboard that helped to define nursing as a profession. At this time, the nursing process was accepted and utilized in nursing practice and education. Moreover, the introduction of the concept of 'clinical reasoning' allowed, through an expansion of the claims made for cognitive tools in safe professional practice, a further legitimatisation and acknowledgement of nursing as a discipline and profession.

How the terms operate signals a difference between the nursing process and clinical reasoning as this relates to what counts as nursing. As its naming would suggest, the nursing process that nursing which can be framed and affords a more systematic approach toward nursing; clinical reasoning focuses on cognitive approach to a situation. The thinking tools for nursing are dealing with less and less obviously 'nursing' issues. Increasingly, the tools for nursing focus on individual and idiosyncratic needs, problem setting and using evidence to generate/justify solutions. There also seems to be more emphasis on how these tools encourage nurses how to think rather than how to use the tools to design and develop curriculum as they have in previous decades. In other words, using and implementing the nursing process and clinical reasoning in nursing education curricula and nursing practice meant that nursing could be explicit in setting its boundaries.

Thus, nursing became visible by its implementation of the nursing process into what and how nurses were taught, and framed how nursing practice could be measured in the clinic, and in this sense 'what nursing can offer' was explicitly witnessed. These steps were the keys for nursing to deepen and to articulate its knowledge. Nursing

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[146] See the discussion in Chapter 2. I have discussed nursing as knowledge-able profession. I also discussed the nursing process in terms of rationalisation of nursing in Chapter 4 (see p. 102).

became visible as a system of knowledge in terms of its textual descriptions. As Foucault wrote in *The Birth of the Clinic*, visible knowledge enables a group to control knowledge (Foucault 1975, p. 163). This was how the nursing profession built its own knowledge base and defined its own practice area. The thinking tools for nursing played the role of capacity-builder in nursing professional development. How the thinking tools for nursing were used in this process will be discussed in the next section.

Governmentality and tools in the nursing profession

Implementing the new tools in nursing education and practice has characterised how the governing of the nursing profession occurs. According to Foucault: "Discipline 'makes' individuals; it is the specific technique of a power that regards individuals both as objects and as instruments of its exercise" (1977, p. 170). This relationship differs from the 'contract' relationship in modern nursing. This is discussed by Nelson (1996) who shows how where a more subtle and seductive form of power is used to govern nursing professionals.[147]

During the 1950s and 1960s, nursing was a controlled 'discipline' so behaviour assessment was important. The hospital assessment sheet emphasised and assessed by reference to standards of etiquette and student nurses' behaviour such as 'spirit of loyalty', 'reception to correction', and so on (see Appendix 3). Etiquette and behaviour come from a more personally oriented sphere rather than a social and professional sphere. During the 1970s, the contract relationship gradually came to the fore in the implementation of tertiary education in South Australia (and in the other states of Australia). At the same time, the nursing process was also introduced to nursing education.[148] 'What nursing offers starts to be defined and the functions of nursing were enumerated. Nursing professionalism was based on issues that arose from the wider society and its collective behaviours. A shift away from the collective level to a more individual level expanded nursing's professional boundary. Developing, promoting and then utilising the thinking tools of nursing in curriculum design and development, promulgated this shift and helped to position nursing as a knowledge-based discipline.

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[147] See also Chapter 1, p. 6, section, "What can turn 'uncertainty' into 'certainty'?".
[148] See Chapter 6, p. 183.

Disciplined nursing education

Foucault (1977, p. 200) states that the 'contract' relationship does not work as a form of 'discipline' (see Diagram 19), however 'discipline' works within a 'contract' relationship (see Diagram 20). In other words, 'contract' as a social expectation is an assumption (of prisoners correcting their behaviours), whereas 'discipline' is an assumption working on their individual behaviour, which does not interfere with the social assumption. He explained this situation by using the prison supervision system of 'panopticon' as a metaphor for what happens:

> Each individual, in his place, is securely confined to a cell from which he is seen from the front by supervisor; but the side walls prevent him from coming into contact with his companions. He is seen, but he does not see; he is the object of information, never a subject in communication (Foucault 1977, p. 200).

The space created between the prisoners and supervisors creates on 'invisible' relationship of power between them. The prisoners who are kept in limited spaces are expected to behave themselves in their space although they do not know that they are being watched by supervisors, representing authority. This is an example of how authority works on the individual and how discipline influences individual activity
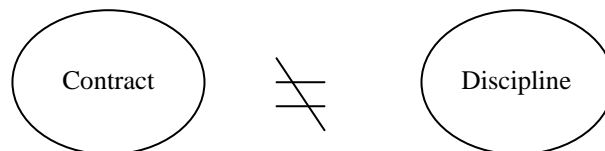

Diagram 19 The relationship between contract and discipline (1)
*These two relationship are not equilibrium.
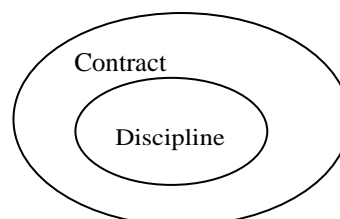
Diagram 20 The relationship between contract and discipline (2)
*These two relationship works when discipline exists within contract.

'Discipline' has long been regarded as a virtue in nursing (see discussion of hospital etiquette in Chapter 6, p. 165-6). During the 1950s and 1960s the behaviour and characteristics of nursing students were more important to assess because nursing training occurred in hospitals and hospitals are forms of architecture that many have cited as sharing panoptic characteristics with prisons as they work to make subjects docile and visible to experts within the structure (Armstrong 1983, p. 458; Cheek & Rudge 1994, p. 587; Foucault 1977). Nursing students and nurses are still observed in much the same way; their behaviour is watched, measured and assessed. The location for teaching nursing has shifted outside of hospitals in the 1970s. In this process, students entered a relationship of 'contract' with the education system. In this situation, the thinking tools for nursing such as problem-solving and the nursing process operate to 'discipline' or perhaps more accurately, govern nursing students.

Governed nursing practice

It is also noticeable that the move to a more governmental process in nursing was influenced by the refined regulatory role of the NBSA in South Australia and ANMC nationally. The organisation's role changes influenced the activities of individual nurses in terms of defining what the professional nurse's role was (see Chapter 6). The texts published by NBSA concerning medication, nurses' roles and their scope of practice all related to the activities and functions of nurses. Although function is not defined by place any more, professional organisations such as NBSA and ANMC oversee the functions of practising nurses instead. For example, 'the scope of practice decision making tool' published by the NBSA in 2006 states that the aim of this tool is:

> to assist in decision making processes and self assessment by
> nurses, midwives and their employers to critically examine and
> expand their scope of practice where appropriate (p. 2). [149]

This description is explicitly about the need to 'govern' nurses. As in Foucault's philosophy, the nursing profession and its regulatory practices now governs nurses from a distance in that nurses are themselves, with their employers capable of

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[149] Here, the tool means "a scope of practice decision making tool" published by the NBSA (Nurses Board of South Australia 2006). It aims to support the nurses and midwives in terms of decision making from both levels of individuals and professions (see Appendix 15).

examining, expanding their scope of practice should such a thing be needed (by the employer). The power of nurses becomes individualised, and in collaboration with their employer. Regarding the emphasis on individual activities in the nursing profession, how did the curriculum view its thinking tool? What traits do they possess? The answers lie in the changing descriptions of graduates' attributes, and reveal instances of 'professionality' that may well transform the profession as it meets the needs of flexible health care delivery and other neo-liberal reforms.

Chapter summary

In this chapter, the nursing education curriculum's development from the 1980s to 2007 was analysed. The concept of competency standards came to the fore during this era. Nursing is talked about in terms of these concepts, which it is believed describe nursing. Curriculum as a rhetorical vehicle showed that professional nursing frames the collaborative curriculum around well-rehearsed theoretical concepts such as the person, nursing, health and the environment. These conceptualisations not have to be seen explicitly in the context of curriculum but have become a 'black box' where the processes are re-hidden or assumed. This phenomenon is also evident in the thinking tools of nursing. The tools such as the nursing process, problem-solving approaches and clinical reasoning emerged to promote nurses' thinking and these phenomena took on visible form in its texts. The terms such as problem solving, nursing process, clinical reasoning were frequently used in the 1980s and 1990s curriculum. The thinking tools use the name 'nursing' less and focus on generic cognitive processes applied to nursing. The purpose of using tools shifted from 'knowing what it is' to 'knowing how to use' in nursing practice. The thinking tools for nursing were also used to discipline nursing students at university and keep them docile as their behaviour was watched, measured and assessed. Moreover, nurses utilised these tools to legitimate nursing as professionals; thus, these tools represented a new way to deal with uncertainties and to create certainty in the nursing professional.

Autonomy in the nursing curriculum influenced the relationship between the NBSA and the School in terms of which body oversaw the education of nurses. Nurse

educators achieved governmentality by creating a nursing curriculum that achieved competency. The interactions between other stakeholders in society and the curriculum meant that nurse educators are now more aware of society's inputs into the curriculum and that the output consists of professional knowledge-based nurses.

CHAPTER 8

CLOSING THE SCENE

Introduction

This chapter will summarise the findings and implications of this study. A Foucauldian approach provides insights through an exploration of a history of nursing professionalisation discourses. I claimed that there is a difference between the nursing profession and medicine's approach to dealing with uncertainty (Fox 1957). Fox's discussion of uncertainty is based on knowledge-based disciplines such as medicine and science, in which discipline uncertainty was more likely to be controlled by using a problem-solving approach as the uncertainty lay in the clinical environment and lack of knowledge with which to deal with clinical situations. In the nursing discipline, uncertainty was dealt with through different processes. To overcome knowledge-based uncertainty, nurses used strict supervisory structures, roles and procedures. A further form of uncertainty for nursing was the lack of recognition of its expanded role and professional status by the wider society. In 2007 nursing is recognised as a profession and it is believed that a nurse makes decisions basing on the evidence-based knowledge. Uncertainty in the social sphere in terms of whether nursing is a profession or not is not a point for discussion. However, internal threats to the nursing profession continue and nursing professionals have found different ways to manage further uncertainty through the use of concepts such as the nursing process, problem-solving approach and clinical reasoning.

Revisiting the purpose of this study

This thesis has investigated nursing professionalisation in South Australia since the 1950s to 2007 through a genealogical approach to the analysis of nursing discourses. The definition of nursing between 1955 and 2006 shows vast contrasts. The influences of these changes delivered various processes that nurse educators, managers and other leaders managed to bring to bear on the professionalisation

project. What promoted this professionalisation project was not only the nurses who wanted to be recognised as professionals, but also external influences such as the women's movement in the 1960s and 1970s, increased knowledge requirements brought about by developments in medical technology, economic developments, and professionalisation of the health and other areas of expertise since World War II.

Therefore, the nursing profession was encouraged by changes in society to re-create the functions that nursing undertook on behalf of society and nursing in turn produced its own disciplinary foundations. Seeing this process as one that is a balance between internal and external forces is essential to understanding the form that the contemporary nursing profession takes. The control of its professional boundaries is managed through a process of and for 'uncertainty control'. These interactions with wider societal forces brought nurses into the social sphere and away from a singular focus on the individual nurse and patient. The shift from a personal focus to social focus accompanied increases in the complexity of the technological delivery of health care in Australia, as discussed in Chapters 2 and 3. The operation of discourses in sociological knowledge underpinned nursing's professionalisation agenda in Chapter 2 and provided mechanisms to support arguments for expanding the roles of nurses in Chapter 3. The influences on nursing professionalisation were corroborated by looking at genealogical threads in each chapter. Chapter 4 described the discourses of nursing process and showed how these discourses supported nursing becoming more professional in its orientation. Chapters, 5, 6, and 7 showed how the thinking tools, such as nursing process, were implemented by nurse educators who used the curricula as a rhetorical vehicle bearing their nursing ideals.

Professionalisation discourses

I identified the layers of professionality by exploring the discourses of 'professionalisation' in Chapter 2. It provided the framework for how a profession is talked about and thought about in contemporary western societies such as Australia. An intertextual examination of texts indicated that nursing had layers of professionality, some reliant on the sense of religious calling and even though nurses acted as leaders, with higher degrees, they were not recognised as such. Moreover,

calling is still used to recruit nursing students and integrated into the elements of nursing professionality. Nursing professionality was talked through the layers between the virtue script of nursing and knowledge-based nursing. Nursing needed to utilise the virtue script to legitimatise nursing as a profession while nurses were constructing their knowledge as professionalisation project.

As I analysed the elements of professionality based on the current competency standards, what differentiated professionality in earlier definitions of 'profession' was a lack of sufficient description or definition of professionality such as disciplinary knowledge, autonomy of practice and ethical duties as a profession; which also had a traditional male-centred view of altruism. From the point of view of the traditional professions of church, medicine and the law, there was no room for excluded groups such as nursing. However, as the sociological discourses on professions shifted their emphasis, these alternative discourses were used to define what a nursing profession would look like.

Chapter 3 showed that the nurse's roles moved from one situated in the personal sphere to one more aligned with the requirements of the wider society. According to 1950s and 1960s descriptions, and located in the personal, nurses were expected to work as hand maidens of doctors in the hospitals. Training programmes were controlled by the Nurses' Registration Board whose membership was predominantly that of doctors. In such a situation, nurses did not control what they learnt, nor could it be said that what they learnt was 'nursing'. In other words, nurses did not have clear characteristic of professional practice, which was supported with autonomy. The attributes of graduate nurses in the hospital-based training system focused more on personal attributes such as loyalty, punctuality, truthfulness and generosity, and so on. In other words, the place and control of training and work influenced what could be thought of as 'nursing' and what was done by nurses.

Accompanying the shift in society's beliefs about professions as well as the needs of the health care system itself, associated changes in structures of education occurred. In the texts, nurse education transformed from 'training and apprenticeship' to 'education', and 'student nurse' to 'nursing student'. Personal attribute assessment

was much less important, and assessment was now undertaken on how nursing students thought about and practised nursing. Graduate nurse attributes show that nurses were expected to not only be capable of performing nursing procedures, but also to have problem-solving and decision-making abilities. In other words, the professional socialisation of nursing students became a central to assessment of them. The knowledge shift internal to the nursing profession mirrored the external changes in how the nursing profession was viewed and portrayed. The description of the nurse's role statement shows these changes in describing nurses as a 'member of a health system' and under the rubric of 'all professional interactions'. The interactions of nurses are not only toward patients but also to other 'unnamed' professionals practising in the health care system.

The place where the thinking tools of nursing is used also promoted divergence in thinking about nursing as discussed in Chapter 4. The nurse educator who wanted to teach 'good nursing' to nursing students used the process of nursing and the nurse practitioners who wanted to improve nursing practice took up 'the nursing process'. These differences in purpose between the nurse educators and nurse practitioners were about the different strategies in each realm: one was to assure the quality of care, and the other was to promote students' learning about nursing. Such divergence created confusion regarding its use, how it best be implemented in the curriculum and teaching and threatened the clarity between the roles of nurses and medical doctors. This differentiation process was argued in Chapter 4 and two implications for nurses lying behind this divergence were pointed out; effects on the socialisation into nursing by nursing; and influences of science and technical rationalities on nursing.

Curriculum as rhetorical vehicle and thinking tools for nursing

I explored the genealogy of curriculum development and design and its correlation with the thinking tools of nursing through an analysis of nursing professionalisation. The different forms of curricula assume different ideas and understandings about students, learning and teaching. The developments in educational theory, as with the changes in what counted as a professional, provided a vehicle for nurse educators,

many of whom undertook degrees in education when there were no other forms of study for registered nurses. These changes provided a rich array of approaches to education that supported the use of the thinking tools for nursing to be used in nursing education. How the curriculum contained these thinking tools highlighted the generation of nursing knowledge and expertise. It acted as both a form of resistance to and use of governmental strategies to promote the nursing professional agenda, the autonomy of nurse educators and later was used by regulatory authorities to re-assert control of the nursing professional agenda through the competency movement. From the operation of the nursing process to clinical reasoning these changes in thinking about nursing wrought changes to the possibilities for the profession in the changing world of health care.

The operations of governmentality in nursing were transformed through disciplinary practices in hospitals where behaviour was characterised at the personal level. This focus on individual behaviour shifted to one where the group was governed by professional organisations. In other words, in terms of professional behaviour development, nurses had to move away from the personal sphere to learn about group behaviour by taking other disciplines into nursing. This group behaviour as professional behaviour was later developed into a framework for the ethical conduct of nurses and competency standards.

It took some time to teach these professional behaviour at a nursing school, because there was little sense of curriculum when the student nurses were 'trained' in the hospital around the 1950s. The syllabus was prescriptive and descriptive and nursing knowledge was based largely on tradition, house keeping and medical knowledge. The nurse trainees learned by repeated experiences and were lectured by medical doctors. As I discussed in the previous section, the shift in location to universities brought with it a sense of control over nursing curricula. This shift turned the trainees into nursing students but also the curriculum represented a device to attain autonomy. In this transformation to a governmental rather than disciplinary process, the thinking tools also promoted nursing's professionality by clarifying what could be considered as the functions of nurses. The tools and skills that nurses gained in the first instance included medical technology, and the skilled nurse ideally gained professionality at

the same time (Sandelowski 2000). Norman describes the relationship between human development and the tools as follows (1993, pp. 4-5):

> We humans have invented a wide variety of things to aid our cognition, some physical, some mental. Thus tools such as paper, pencils, calculators, and computers are physical artifacts that aid cognition. Reading, arithmetic, logic, and language are mental artefacts, for their power lies in the rules and structures that they propose, in information structures rather than physical properties…But whether physical or mental, both types of artefact are equally artificial: They would not exist without human invention. Indeed, anything invented by humans for the purpose of improving thought or action counts as an artifact, whether it has a physical presence and is constructed or manufactured, or whether it is mental and is taught. The technology of artifacts is essential for the growth in human knowledge and mental capabilities. Think of where we might be without written history or without the development of logic, arithmetic, or skills of reasoning…

Nursing professionality has been raised with both physical and mental artefacts. The physical artefacts (medical tools) and mental artefacts (the thinking tools for nursing), are needed to control and regulate the boundaries of uncertainty in the nursing profession.

The relationship between the thinking tools of nursing and curriculum development

The curriculum showed changes by implementing the thinking tools for understanding what nursing does. 'Problem solving' has been a core thinking tool for nursing and as historical analysis of the curriculum shows how and in what way these tools are embedded in learning processes. The emphasis on problem-solving and ability to carry out this process accelerated nurses' accommodating of these rationalised processes. Nursing process seemingly describes with clarity what nursing does and how nurses function. However, this thinking tool diverges in terms of its how application thinking about it and the ways that it defined nursing processes. Nursing process has proved to be controversial in regard to its application into nursing practice.

In nursing curriculum development, I noticed that the description of 'nursing process' and 'problem solving' were interchangeable and mutable. When these tools

were introduced into the curriculum for the first time, the initial objective was for the student to learn how to use these tools in their practice as nurses. Although the curriculum promoted a learning approach to nursing as Orlando claimed originally, the concept of the nursing process was translated into 'how to use' and 'when to use' rather than as a process of nursing. The nursing process was influenced by scientific ways of thinking that emphasised problem-solving approaches in order to be considered a professional. In this sense, nursing risked losing its individualised approach to the relationship between a nurse and a patient as portrayed in Orlando's, Peplau's and other early nursing theorists' work. Rather, the nursing process as promoted by Yura and Walsh (1967, 1973) was a technique that was to provide a scientific process for solving patient problems. Investigation of the formation of discourses about nursing process showed how discontinuity as Foucault (1972) called this phenomenon happened in the thinking tools for nursing by differentiating the purpose of tools' use and utilisation in nurse education and nursing practice. In the nursing process concept, a nurse examines the condition of a patient. There is an effort to distinguish the problems working through these processes, although there are differences between medical doctors and nurses in terms of what each of them try to differentiate. Working on the patients' problems refers to discontinuity in the process nursing concept as discourses of the nursing process indicated. In other words, holism was lost from nursing. However, it is not total discontinuity. It was a temporary loss of the focus on individuality in the relationship between a nurse and patient. Nursing emerged from this discontinuity as a knowledge-based discipline, through the debates over what constituted knowledge, professions and education at a time when many professions were undergoing change.

The use of nursing thinking tools such as nursing process, problem-solving approach and clinical reasoning also demonstrate a process of change in nursing education. These changes over time show that reform of the cognitive strategies was regarded as the tool for controlling uncertainties in nursing practice. Clinical reasoning, especially illustrated this change process in nursing education. This thinking tool sought to promote the students' learning process through links to clinical experience. Students were expected to use clinical reasoning skills to learn and advance their competencies during their nursing education. It also shifted the thinking tool from

'rule-driven thinking' such as step-wise problem solving as promoted in the nursing process to clinical reasoning based on a conceptual approach to nursing. During their nursing course at university, students were expected to be able to move from 'knowing what rule' to 'what brings the rules' through learning clinical reasoning.[150]

Transformation in curriculum

Through historical analysis of curriculum in the case study, nursing curriculum changed from a 'recipe of nursing' to teaching and cultivating 'the way to thinking in/about nursing' and a 'way to deal with uncertainty in nursing practice'. In other words, nurse educators changed how curriculum was practised. Furthermore, who or what part of the profession controlled the curriculum influenced the curriculum's construction. The number of stakeholders in curriculum development has increased. For example, the 1950s curriculum was controlled by the NBSA, whereas the later curricula between 1992-2007 were controlled by a variety of stakeholders, one of the many being the Nurses Board. The increase in stakeholders also shows that the nursing curriculum does not only belong to the state through its regulatory authority (NBSA). The context of nursing education allowed schools to lead in the debates about how to think about nursing. The direction of nursing education at this school in the case study was left to the school's leaders, who collaborated with the curriculum stakeholders. Finally, the school's thinking about nursing was more flexible and relied on the school's self-governance. Diagram 21 in next page shows the relationship between the present curriculum and the other stakeholders.

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[150] In the course book, clinical reasoning is emphasised rather than focusing on assessment purely of skills, which was the key emphasis in the past (Flinders University of South Australia School of Nursing 1992, p. 33).
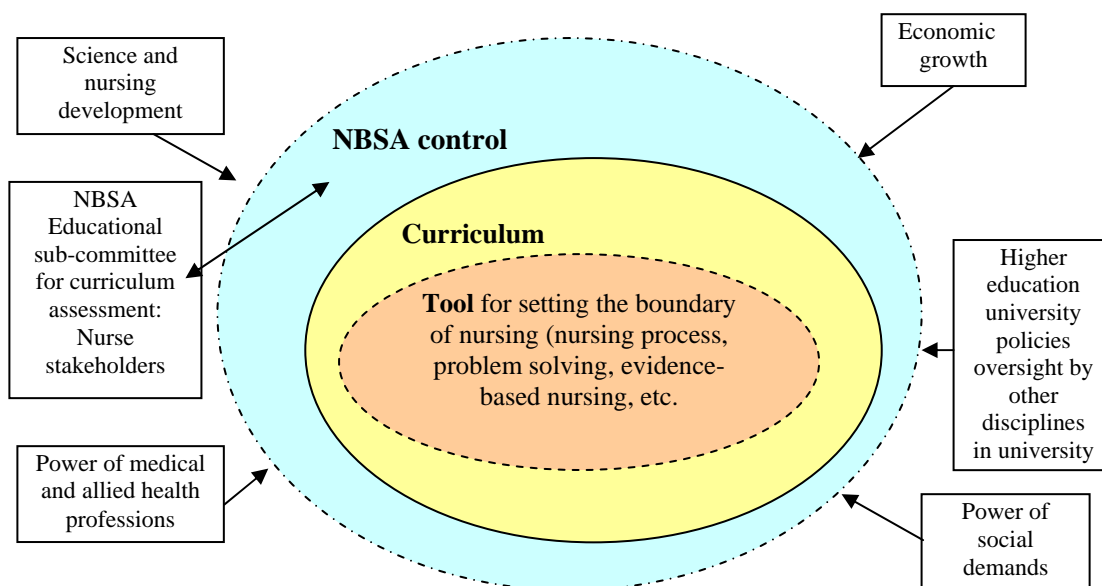
Diagram 21: Description of the present curriculum and power relationships

The thinking tool is situated and embedded in the curriculum but does not control either the process of the curriculum or the product. I consider that the curriculum is similar to a 'basket' for containing the tools and ideas external to the nursing profession. These are: power of societal demands, economic change, power of other health professions, science and nursing development and the regulatory arm through its response to the NBSA educational sub-committee for curriculum assessment. The first curriculum in Diagram 14 (see p. 164) showed that the curriculum was controlled by the Nurses Registration Acts of 1920 and 1922. The current curriculum is now indirectly controlled by the Nurses Board through an 'accreditation' process undertaken by the school about its curriculum. The difference between the first and the present curriculum diagram shows that what governs the curriculum is more influenced by developments in nursing and social realities such as economics, and medical profession, than by the regulatory authorities alone.

The present curriculum portrays the tensions between social influences and internal elements while the discourses operate to maintain what counts as professionality in nursing. The curriculum as a rhetorical vehicle is more overtly political in its implications for nurses with nurse educators trying to maintain nursing as an acknowledged knowledge-based profession. The discourses produced through these

interactions focus on the control of uncertainty in the nursing profession and nursing education.

The importance of controlling uncertainty in professional education

There are many contradictions in nursing education found in this study. The re-location into tertiary institutions made nursing knowledge visible so that nursing would count as a discipline and allowed its professional status to become a reality. However, as I showed Diagram 21 in the previous page, the stakeholders from the external sphere influenced nursing professionals and this requires a continuous balancing act between the health care and educational spheres. The nursing curriculum provides a form of governance or control of the boundaries of nursing professionality through education. Nurse educators construct the curriculum to situate nursing students as learners and also constitutes what counts as a professional nurse.

Moreover, the place of a profession, and the continuous re-negotiation of the grounds for that status are continued threats to nursing being seen as a self-regulating profession. These threats work through a process that is carried from the external to internal spheres of nursing and reflects on the outcomes for an individual nurse. Similarly, place and time to learn is always an issue for nurse education (see discussions in Chapters 3 and 5). Governance of place and time having nurse education was taken over by higher education sectors since completing its transition, however constraints in nurse practice such as workforce shortage, business and shortage of practice venue and so on challenged nursing students.[151] Thus, nursing education is always confronted and challenged by these contradictions to bring professionality in nursing students.

Nursing educators control the design and development of curriculum in order to reduce external uncertainties and regulations as these are threats to how students are

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[151] There was a plan suggested in the 2007 Federal Election Campaign for Enrolled Nurse education to return to hospitals Enrolled Nurse (Phillips 2007). See also the discussion in Chapter 2, p. 36.

to achieve their professional development as part of the operation of the curriculum. Currently, the thinking tool of clinical reasoning is used as one solution. Students are expected to be autonomous practitioners by using this tool and in this way control any uncertainty during their professional learning journey. Nurse educators also need to be aware of this uncertainty control to maintain nursing as a knowledge-based profession at the individual and group level. Uncertainty control at different levels (agent or structure) brings contradictions into play when nurse educators seek to control more and govern the students in ways that do not encourage professionality. In that situation, governmentality works less over nursing professionals but works inwards onto nursing professionals. As I claimed in Chapter 1 (see p. 4) with Fox's citation, professional training needs to focus on knowing uncertainty rather than dealing uncertainty. Thus education for uncertainty in a model as espoused by Fox (1979) requires that educators use different a curriculum than they do at present.

Implications for nursing education as professional education

Given the contradictions in professional nurse education, the stakeholders who are interested in and are involved in nurse professional education may find. I will point out the directions for future investigation as a result of this study. I will summarise these as follows:

- the ongoing challenges to consensus between nursing practice and nursing education based on the concept of 'nursing education as professional education';
- the extent of awareness of
  - differences between education and professional education;
  - nurse educators in bringing external influences (social trends and movements relating to nursing) into nursing education;
  - nurses educators to continuous threats to the nursing profession and maintaining the nursing profession as a knowledge-based profession and the effects of using nursing thinking tools.

The methodological implications for nursing research

I will discuss the three major implications of this study. Firstly, I suggest that the focus has shifted from the history of thoughts to the history of practice. Primarily this study focused on the process of a shift from external effects on nursing to internal effects on nursing and it investigated nursing knowledge in terms of nursing/ nursing education practice to see how knowledge was utilised in practice. D'Antonio (2006, p. 247) claims that we need to explore the history of nursing practice to "look to our historical studies and think more deliberately, ambitiously, and boldly about the views we see and their place in the creation of new ideas". I also point out that nursing has only had the thinking tools for a short period. Nursing knowledge and evidence have developed dramatically since the 1950s and the foundation of discipline-based schools supports this. As D'Antonio (2006) suggests, practice occurs daily, and continuously.

Secondly, I demonstrate the value of the Foucauldian perspective and use of discourse in historical study. Analysis of the discourses emanating from the external and internal spheres of the nursing profession, in other words what the current nursing profession constitutes and how this constitution has been established, was central to this thesis. Therefore, I conclude that Foucault brought valid insights to the nursing profession. Foucault's thoughts described in *The Birth of the Clinic* informed how nursing knowledge developed through the utilisation of nursing tools and it influenced practice and education.[152]

Finally, this study's methodological perspective shows that history is not only about periodization. Hallett (2007 p. 429) wrote, "The periodization I would like to propose for nursing is based less on knowledge than on ethics and values". As I described in Chapter 1, the study concerns how knowledge is thought of rather than what actually happened. The Foucauldian perspective and discourse analysis make explicit what made nursing 'professional' in terms both external and internal to the nursing profession. *Episteme* in this study was the operation of governmentality in the

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[152] The growth of thinking about clinical education differed from that of medicine in the mid-19th century. In medicine, clinical education was developed through advances in scientific technology that assisted in curing patients.

nursing profession and *enonces* producing and constituting this as an *episteme* were discourses about the processes of nursing process and its change to the nursing, the recruitment of more generic problem-based approaches, nursing competency movements, and more recently to the use of clinical reasoning as a way to inform professional nursing practice.

Is this investigation applicable to all?

There are three points that I consider to be limitations to this study. Firstly, the study focused mainly on South Australia. This limits the applicability to other contexts regarding nursing professionalisation. Nursing is greatly influenced by the society in which nurses' work and therefore definitions of nursing will differ across cultures. It is inevitable that this study cannot be generalised for this reason. If nursing is described in terms of differences in practice, nursing in different societies is not concerned with functional issues. The objective of nursing in any society is to create stability and order even though societies around the world are culturally different.

For example, Stower's (2005) presentation shows these differences in nursing. She stated in her paper at The Virginia Henderson Lecture at the ICN 23rd Quadrennial Congress in Taiwan, 2005:

> In accepting Virginia Henderson's definition of nursing, ICN – as the acknowledged world authority on nursing – has unreservedly declared that this definition is applicable and therefore relevant to any country situation in both the developing and developed world. However, I am challenged by this opportunity to realistically revisit and re-analyze this definition from the perspective of a struggling developing country with a strong traditional cultural foundation, where a health system that is heavily dependent on a diminishing nursing workforce is being revamped and changed in accordance with the economic reforms prescribed by IMF [International Money Fund], World Bank and other well meaning international development partners and donors.

She raised the issue, "The key question I am raising today is whether the Virginia Henderson definition could have prepared the nurses, especially those of the developing world, to manage this changing health care context that could even be

dubbed a 'context on the move". This study's focus is limited to the Australian context and does not apply to the other countries' situation or even to the other states of Australia.

Secondly, some key texts were not available. In the early stage of data collection, I discovered that some key texts such as the 1950s curriculum from the Royal Adelaide Hospital nursing school were missing.[153] I tried to find related texts from such organisations as the Nurses Board and other books and undertook personal communication with various health professionals to make up for this data shortfall.

Finally, I am a registered nurse who was educated overseas and is a recent migrant to Australia. I was born and brought up overseas for twenty five years and I have not experienced or heard many of the discourses directly. However, I was challenged to understand these discourses by reading and listening to the experts who had experienced and been involved in nursing debates to enhance and bring richness to the context of this study.

Conclusion

This thesis explored the governing processes of the nursing profession in South Australia. Nurses and nurse educators developing the nursing professionalisation agenda used sociological knowledge, the nurse role statements and competency standards etc. to shape new views of professional nursing behaviour. 'Training' to form the personal characteristics of nurses shifted to 'learning' how to think and to possess nursing group behaviour. Although uncertainty from sources external to nursing professionals has decreased, uncertainty from sources internal to nursing continues such as in the area of nursing practice. The complexity of controlling uncertainty in the nursing profession is produced through changing the focus between the agent and structure, and place and time to learn nursing. Nurses and nurse educators gained governance of nursing education by controlling these forces. In this atmosphere, the thinking tools for nursing were used to discipline nursing

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[153] I explained the training school class system in Chapter 3, see p. 128. Class A means that the training school was able to provide the complete training for nursing students.

students; as a result, to learn to govern nursing. Mastering tools is replaced as the purpose of leaning nursing. Nursing is not only about mastering tools and skills although nurses had to acquire them to professionalise themselves. Nurse educators need to be aware of those aspects essential for nursing professional education. By developing this as a strategy for nursing professionals, nursing will be kept as a knowledge-based discipline.

APPENDICES

The contents of appendices

Appendix 1: Table of the role of nurses' description from historical texts

The publication year and the documentation source	Statement for the role of the nurse since 1950s and the other related incidents (Citations from textbooks and governmental papers)
1955 Virginia Henderson "Basic principles of nursing care"	"Nursing is primarily assisting 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. It is likewise the unique contribution of nursing to help the individual to be independent of such assistance as soon as possible"
1963 "Modern practical nursing procedures" 10th edition	The professional nurses minister to the sick. They assume responsibility for creating a physical, social and spiritual environment which will be conductive to recovery; they stress the prevention of illness and promotion of health by teaching and example. They render health service to the individual, the family and the community and coordinate their services with members of other health professions.
	In the section of "Ethics and Hospital Etiquette" (Extracted from the quarterly New Letter of the National Council of Nurses of Britain and Northern Ireland, December 1953) 1. The fundamental responsibility of the nurse is threefold: to conserve life, to alleviate suffering and to promote health. 2. The nurse must maintain at all times the highest standards of nursing care and of professional conduct. 3. The nurse must not only be well prepared to practice, but must maintain her knowledge and skill at a consistently high level. 4. The religious beliefs of a patient must be respected. 5. The nurses hold in confidence all personal information entrusted to them. 6. A nurse recognises not only the responsibilities but the limitations of her or his professional functions; recommends or gives medical treatment without medical orders only in emergencies and reports such action to a physician at the earliest possible moment. 7. The nurse is under an obligation to carry out the physician's orders intelligently and loyally and to refuse to participate in unethical procedures. 8. The nurse sustains confidence in the physician and other members of the health team; incompetence or unethical conduct of associates should be exposed but only to the proper authority. 9. A nurse is entitled to just remuneration and accepts only such compensations as the contract, actual or implied, provides. 10. Nurses do not permit their names to be used in connection with the advertisement of products or with any other firms of self advertisement. 11. The nurse co-operates with and maintains harmonious relationships with members of other professions and with her or his nursing colleagues. 12. The nurse in private life adheres to standards of personal ethics which reflect credit upon the profession. 13. In personal conduct nurses should not knowingly disregard the accepted patterns of behaviour of the community in which they live and work.

	14. A nurse should participate and share responsibility with other citizens and other health professions in promoting efforts to meet the health needs of the public – local, state, national and international. "It is customary for nurses to stand in the presence of doctors, matron, sisters and senior nurses. The sprit which makes one observe hospital etiquette is ethical. It demands loyalty, and a cheerful co-operation with all those with whom the nurse comes in contact – the patients and their relatives, medical officers, matron, sisters, fellow nurses and other members of the hospital staff and the general public…nurses will be courteous and understanding of the anxiety of relatives…"
1967 The role of the trained nurse with direct patient responsibilities in the wards of public hospitals in the state of N.S.W. by Robert Gillam	The observed result of the sister's activities were generalized as the seven activities as follows; 1. Basic nursing …Typical nursing activities record under this heading were bedmaking, personal hygiene, toilet requirements and feeding. 2. Technical nursing ...Typical activities were pre-and post-operative care, urianalysis, dressings, administration of drugs, attending to and assisting medical staff, preparation of trays, the taking of blood pressure, the administration of enemata and catherization. 3. Teaching "The direct or indirect instruction of trainee nurses and of resident and student medical staff. Indirect instruction included such activity as the close supervision of a trainee's work. In the event, no medical students were present in the wards observed and no teaching of resident medical staff, who were present, was observed". 4. Domestic Those activities of a purely "housekeeping" nature such as linen sorting, cleaning, arranging and removal of flowers, dusting, preparation and serving of food, washing-up. 5. Miscellaneous 6. Unaccounted 7. Administration
1972 The role of the nurse in Australia (Prepared for the NHMRC by Ruth White)	"The present role of the registered nurse, in direct personal care is enacted almost entirely within the hospital. The proportion of nursing time available for fulfilment of the role varies according to the organisation of the institution. It is not an exaggeration to state that in general hospitals (excluding specialist wards) at least half to three-quarters of nursing time is not spent on direct care function. Meanwhile, in situation where there appears to be little impediment to the full use of professional nursing knowledge and skills, together with community health needed waiting to be met, the role of the nurse has not been extended or expanded (p.9)".
1973 NHMRC The report of the 76th session of the council (NHMRC 1974)	"For the individual patient, doctor and nurse together provide care for the whole person within particular areas and levels of expertise. In addition to providing basic physical care, the nurse is healer, adviser, comforter, and technician. Of these, the functions of healer or treater have been predominant"

1977 International Council of Nurses (ICN)	Using the code for nurses from International Council of Nurses. "**A nurse** is a person who has completed a programme of basic nursing education and is qualified and authorised in her/his country to practice nursing. Basic nursing education is a formally recognised programme of study which provides a broad and sound foundation for the practice of nursing and for post-basic education which develops specific competency". They also cite the definition of the function of the nurse by Virginia Henderson. "**The unique function of the nurse** is to assist the individual sick or well, in the performance of those activities contributing to health or its recovery (or to peaceful death) that he would perform unaided if he had necessary strength, will or knowledge. And to do this in such a way as to help him gain independence as rapidly as possible".
1977 ICN Code for Nurses Ethical concepts applied to nursing (Tate 1977)	'It was not until 1953 that the first code of ethics was finally written and accepted at the congress in Sao Paulo, Brazil'. The code was revised twice in 1965 and in 1973…This code is a broad statement of the nurse's responsibility as a professional person. It touches upon many new areas of nursing responsibility and accountability'. 'The fundamental responsibility of the nurses is fourfold: to promote health, to prevent illness, to restore health and to alleviate suffering'. The book explained how nurses should behave in terms of 'nurses and people', 'nurses and practice', 'nurses and society', 'nurses and co-workers' and 'nurses and the profession'.
1977 RANF	"Goals in nursing practice"
1978 Declaration of Alma-Ata	The concept of health was defined. In the conference, the definition of health was described as follows; "The Conference strongly reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector".
1978 Federal Report	"Sax Report"
1979	The Federal Council of RANF authorised the development of a national nursing quality assurance program. Two committees were set up; the National Quality Assurance Committee (NQAC), and the Professional Development Committee (PDC).
1983 Standards for nursing practice complied by	The three core standard is set. 1. The registered nurse fulfils the obligations of the professional role 2. The registered nurse in all professional interactions

Royal Australian Nursing Federation, National Professional Development Committee (second edition has published in 1989)	3. The registered nurse provides effective and holistic nursing care Under these standards, the nursing behaviours are described in detail.
1983 National Health and Medical Research Council (NHMRC 1983)	**The role of the nurse** in Australia varies according to the geographic location and the population with whom the nurse works, the particular type of hospital or health unit in which the nurse works, the stated aims of the employing authority, and the expressed health needs of the community. Wherever the nurse is working, however, he or she is responsible for assessing the nursing needs of the patient, client, family or community, and identifying the resources required to meet those needs. The nurse works with the patient/client to plan the nursing care required, undertake what has been planned, document what has been done, and evaluate the results of the care that has been given. In providing services to the patient/client the nurse delivers comprehensive care rather than a series of isolated tasks or activities. To accomplish this the nurse co-ordinates client care and co-operates with other health disciplines. **Nursing in Australia** reflects the social, educational and political environment of the population in general, as well as the nature of the health services provided, and the nurse shares with other citizens the responsibility for initiating and supporting whatever action is necessary to meet the health and social needed of the community. Because the population structure of Australia has changed to a multi-cultural society, the nurse should take more account of the different health perspectives of people from diverse ethic backgrounds, and recognise that health is a constantly changing state of physiological, psychological, social and spiritual well being arising out of the interaction of people with their environment.
1984 "Nursing in Australia: A National Statement" (RANF 1984)	In the section of 'Nursing and the Role of the Nurse' it says; "Nursing as a Health Care Service – Nursing is a health care service which is provided to people in society. The primary responsibility of the nursing profession is to provide direct health care and education for people in relation to the prevention of illness, the promotion, restoration and maintenance of optimal health, and the achievement of a dignified death. Nursing is practised in all settings in society where people are experiencing varying degrees of health, ill-health and dying".
1985 Nursing Quality Assurance (complied by Royal Australian Nursing Federation, National Professional	Quality assurance is described basing on the problem solving. the report also states; "The primary purpose of a quality assurance program is to provide data that allows judgements to be made about the care received by patient/clients, the performance of nurses, or the effectiveness of the organisation of the nursing division…" The purpose of the report id to introduce a quality assurance program in nursing division so that the explanation of the organisational structure model

Development Committee)	is shown in the report.
1987 Australian Nurse Registering Authorities Conference (ANRAC)	**The Registered Nurse** is the first level nurse who is licensed to practice nursing in the fields in which he/she is registered without supervision, and who assumes accountability and responsibility for his/her own actions. The nurse is also referred to as the professional nurse. **The role of Registered Nurses** includes the following integrated components: clinician; care coordinator; counsellor; health teacher; client advocate; change agent; clinical teacher/supervisor. **The role of the Registered Nurse** includes the responsibility to examine nursing practice critically and to incorporate the results of personal action research or the research findings of others. It is the Registered Nurse's responsibility to understand the role and function of enrolled nurse and to ensure that they are placed in situations where they are required to function only within the limits of their education and competence. The registered Nurse determines, on the basis of client needs, whether nursing will be given by Registered Nurse, whether nursing will be given by a registered nurse or an enrolled nurse.
1988	"Health for All Australians". Health Targets and Implementation (Health for All) Committee.
1989 Guidelines for National Nurses' Associations "development of standards for nursing education and practice" By ICN	"The nurse" Standards should address "who is the nurse", specifying qualifications for practice and requirements for licensure, such as the determination of required competencies at "entry to practice" level. The accountability and responsibility of the individual practitioner to consumers and employers is demonstrated by the behaviours of the nurse in carrying out the professional role. Accountability is also shown in the activities of the nurse in relation to the nursing profession and in participating in the advancement of the profession, as well as to the nurse him/herself as shown by practicing and marinating through continuing education a high level of quality in practice. Adherence to ethical principles or a code of ethics should be stresses as well as compliance with legal customs. The rights of nurses to practice and the unique nature of the nurse client interaction can establish the role and function of the nurse as an autonomous health professional, independent of other professions yet working in close collaboration to serve the public (p. 12).
1989 Standards for Nursing practice	Second edition, complied by Australian Nursing Federation, National Professional Development Committee
1989	The role of nurse in nursing care encompasses the promotion of health; the

Nursing in Australia: A national statement (ANF 1989)	prevention of health breakdown; the care of physically and mentally ill, and disabled and dying people of all ages in all health care settings; and the facilitation of spiritual integrity. Nurses work with people who are healthy as well as with those who have some manifestation of health breakdown.
1990 ANRAC	**"National Competencies for the Registration and enrolment of Nurses in Australia"** "The competencies outlined in this document were approved by all state and territory nurse registering authorities at ANRAC 1990…they apply to graduates of nurse education courses, nurses seeking to re-enter the profession and nurses from overseas counties. ANRAC is promoting the use of the national competency statement in curriculum development for nurses education in all states and territories of Australia." There are 18 competencies in the booklet. 1. Demonstrates a satisfactory knowledge base for safe practice. 2. Function in accordance with legislation and common law affecting nursing practice. 3. Maintains a physical and psychological environment which promotes safety, security and optimal health. 4. Recognises own abilities and level of professional competence. 5. Carries out a comprehensive and accurate nursing assessment of individuals and groups in a variety of settings. 6. Formulates a plan of care in consultation with individuals/groups taking into account the therapeutic regimes of other members of the health care team. 7. Implements planned care 8. Evaluates progress toward expected outcomes and review plans in accordance with evaluation data. 9. Acts to enhance the dignity and integrity of individuals and groups. 10. Protects the rights of individuals and groups. 11. Assists individuals or groups to make informed decisions. 12. Communicates effectively and documents relevant information. 13. Demonstrates accountability for nursing practice. 14. Conducts nursing practice in a way that can be ethically justified. 15. Acts to enhance the professional development of self and others. 16. Recognises the value of research in contributing to developments in nursing and improved standards of care. 17. Collaborates with the health care team. 18. Effectively manages the nursing care of individuals or groups.
1990 The identification and assessment of competencies: The nursing project and its implications By Jim Butler	The research report was supported by the project of The National Office of Overseas Skills Recognition (NOOSR). The report is base don the ANRAC report and shows the possibilities to implement the nursing competencies into nursing practice.
1991 National Health and Medical	The following role components are adapted from research by Benner and Fenton quoted in the "Report of the Research Project to Develop Role

Research Council (NHMRC 1991) "The Role of the Nurse in Australia"	Statements for Nurses". ■ The clinical, caring role ■ The teaching counselling role ■ The managerial/co-ordinating role ■ The patient/client advocate role ■ The professional developmental role ■ The nurse consultant role ■ The nurse educator/academic role ■ The nurse researcher role
1991 "The implementation of the ANRAC competencies: An examination of pertinent issues" by Maureen Thompson	The purpose of this paper is to identify some issues which relate to the implementation of the ANRAC competencies. There are several authorities involved in setting the nursing competencies in Australia. This report explains the issue in the relationship between the authorities and the ANRAC nursing competencies. Moreover, the report expresses the issues in implementing the competencies in practice and education.
1991	National competency standards: policy and guidelines
1993 Australian Nurse Council Inc.	"National competencies for the registered and enrolled nurse in recommended domains"
1993	Code of Ethics for Nurses in Australia Health assessment guidelines for nurses (NBSA)
1993	Health assessment guidelines for nurses (NBSA)
1994	Nursing education in Australian Universities: Report of the National Review of nurse education in the higher education sector – 1994 and beyond
1994	"Role of the registered nurse in hostels and other supported residential facilities" publication by Nurses Board of South Australia
1997 Lynette Cusack, Morgan Smith and Tess Bynes	"Role of the registered nurse in the community" supported by the Nurses Memorial Foundation of SA.
1998 ANCI National Competency Standards for the Registered Nurse (Second edition)	**The Registered Nurse** is the first level nurse who is licensed to practice nursing in the fields in which he/she is registered without supervision, and who assumes accountability and responsibility for his/her own actions. The nurse is also referred to as the professional nurse. **The role of Registered Nurses** includes the following integrated activities: clinical practice, care coordinating, counselling, health teaching, client advocacy, facilitating change, clinical teaching, supervising, working in a team, mentoring, and researching. **The role of the Registered Nurse** includes the responsibility to examine nursing practice critically and to incorporate the results of personal action research or the research findings of others.

	The Registered Nurse practices independently and inter-dependently in accordance with professional standards, and employs a problem solving approach in practice. It is the Registered Nurse's responsibility to understand the role and function of the health care team including unregistered workers in nursing care and to ensure that they are placed in situations where they are required to function only within the limits of their education and competence and the prevailing context. The Registered Nurse determines, on the basis of client needs, whether nursing will be given by Registered Nurse or whether nursing care will be delegated to enrol nurses or unregistered workers when appropriate.
2000 RCNA(Royal College of Nursing Australia 2000)	"Position statement for self –regulation" Self-regulation is 'the governance of nurses by nurses in the public interest". The process of self-regulation is aimed at "providing evidence that practitioners are meeting society's expectations and maintaining expected standards of practice. Professional self-regulation is not simply defined but contains a number of elements each of which contributes to and is accountable for the overall purpose of the protection of the public. Elements of self-regulation include: setting of professional standards; development of a Code of Ethics and a Code of Professional Conduct; peer review; participation in professional activities and continuing education; research; uncovering new knowledge; professional publications; developing and monitoring advanced practice, and credentialing and certification processes. Individual professional accountability and consumer expectations also contribute to self-regulation through expectations of standards of practice and behaviour".
2000	Your practice: Continuing competence and self-regulation (NBSA)
2002 ANMC National competency standards for the Registered Nurse	In the section of 'For nurses' 'The standard provides a benchmark for nurses in daily practice. They may be used for the academic assessment, workplace performance review and for measuring continuing fitness to practice. The competency standards reflect the unique characteristics of nursing as well as broader attributes nurses have in common with other professions and occupations. In addition, they identify the knowledge, skills and attitudes required by nurses and reflect the complex nature of nursing activities.'
2003 Professional standards statement for nurse practitioner practice (Nurses Board of South Australia 2003a)	"A Nurses Practitioner is a registered nurses educated to function in an advanced clinical role. The scope of practice of the Nurse Practitioner will be determined by the context in which the Nurses Practitioner is authorised to practice. The defining features of a Nurse Practitioner, as described in the SA Nurse Practitioner Project 1999, includes combined roles of educator, mentor, provider, manager and researcher within the context of need, setting, education and autonomy".
2003 Standard Therapeutic Relationships and professional boundaries	Responsibilities of registered nurses and enrolled nurses "…Fundamental to this process is the protection of the rights and wellbeing of the client. As members of a profession, registered and enrolled nurses must practice in the best interests of the client which includes assessment of the need, risks, benefits and alternative methods of treatment proposed given the

(Nurses Board of South Australia 2003b)	nurses' level of expertise and experience".
2006 A scope of practice decision making tool (Nurses Board of South Australia 2006)	"Nurses and midwives are increasingly taking on expanded roles and activities in the interest of comprehensively addressing client needs in a safe and cost effective environment. at the same time, nurses and midwives are reclaiming roles and activities that were previously within their responsibilities. Nurses and midwives are still expected to maintain the core aspects underpinning the philosophy of care and caring. **Nursing and midwifery is not moving incrementally forward rather than it is concentrically expanding** (p. 5)".

Appendix 2: Nursing Registration Acts, 1920 and 1922 (1)

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(1) hereof, is held nearest to the day on which she completes her first 12 months' training, notwithstanding that the said 12 months may not have then expired.

(5) A trainee for the time being serving her period of training in a part-time training school may submit herself for that examination in anatomy and physiology which, as provided by subclause (1) hereof, is held nearest to the day on which she completes her first 18 months' training, notwithstanding that the said 18 months may not have then expired.

(6) A trainee, being once eligible to submit herself for such examination, may submit herself at any subsequent such examination.

Final Examination.

17. (1) The board shall hold examinations in the following subjects of the prescribed course of training in the months of April, August, and November in every year:—

(a) General nursing, public health and hygiene, gynaecological nursing, and the nursing of diseases of organs of special sense;

(b) Medical nursing; and

(c) Surgical nursing.

(2) Such examinations may be held at any whole-time training school or schools appointed by the board, and shall be conducted by examiners appointed by the board.

(3) The examination in any of the said subjects may be theoretical or practical, or may be both theoretical and practical, as the board may determine.

(4) The standards for such examinations shall be the standards indicated by the subdivisions of the subject matter of the examinations as set out in the Schedule B hereto.

(5) A trainee may submit herself for that examination in any of the said subjects which is held, as provided by subclause (1) hereof, nearest to the date on which she completes her prescribed course of training, notwithstanding that she may not have then served the prescribed period of training.

(6) A trainee, being once eligible to submit herself for any such examination, may submit herself for any subsequent such examination: Provided that a trainee shall not be eligible to submit herself for any such examination unless, from the time of passing the examination in anatomy and physiology, she has continued to serve her course of training.

(7) The board may, in its discretion, hold examinations in accordance with this regulation at any time in addition to the times specified in paragraph (1) of this regulation.

(8) Every trainee submitting herself for examination in any of the following subjects under these regulations shall pay to the Board an examination fee of five shillings for each subject in which she submits herself for examination.

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PART I.—TRAINING AND EXAMINATION OF NURSES.

Subjects—

Anatomy and physiology.

General nursing (including hygiene and public health, gynaecological nursing, and the nursing of diseases of organs of special sense).

Medical nursing.

Surgical nursing.

Eligibility for Examinations.

18. If a trainee submits herself for any prescribed examination for which she is not eligible to submit herself, she shall be deemed not to pass such examination.

Examination Certificate.

19. The Registrar shall furnish every trainee who passes any prescribed examination with a certificate to that effect in the form contained in Schedule C.

Proficiency Certificate.

20. (1) When a trainee has served a course of training in any particular subject of the prescribed course of training (other than a subject in which lectures are delivered), and is considered by the person giving the instruction to be proficient in that subject, such person shall furnish the trainee with a certificate to that effect.

(2) In any case where the board has approved of instruction in invalid cookery being given at a school of instruction, a certificate by the instructor or other responsible official of that school that a trainee is proficient in invalid cookery shall be sufficient for the purposes of these regulations.

Sufficiency of Certificates.

21. Any certificate issued or provided for under the provisions of these regulations may be accepted by the board as sufficient evidence of the truth of the matters therein stated.

SCHEDULE A.

Subjects for Preliminary Educational Examination.

English (including dictation, spelling, and a short essay);

Arithmetic (simple);

Writing.

A trainee obtaining fifty-five per centum of the maximum marks obtainable at such examination shall pass such examination.

SCHEDULE B.

The Prescribed Course of Training for Nurses.

PART I.

Subject— *Anatomy and Physiology—Twelve Lectures.*

Subdivisions of subject—

The structural composition of the human body—Bones, ligaments, muscles, arteries, veins, nerves, glands, lymphatics, organs of assimilation, of secretion, and of excretion.

Appendix 2: Nursing Registration Acts, 1920 and 1922 (2)

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The skeleton—Names and functions of various bones ; joints, nature of, chief varieties, functions, ball and socket, hinge.

Muscles—Anatomical description of, action of, names of most important, physiology of muscles.

Arteries and veins—Structure and functions, names of, position of chief arteries and veins.

Nervous system, brief sketch of—Brain, structure and functions ; spinal cord, structure and functions ; motor nerves, structure and functions.

The heart—Structure and functions, its position.

The circulation.

The blood, its constitution and use.

The lungs—Structure, position, functions. Respiration.

The larynx—Speech.

Animal heat.

Digestion and absorption.

Mastication—Teeth.

Saliva and salivary glands.

The Stomach—Its position, structure, and functions.

The small intestines—Position, structure, and functions.

The colon—Position, structure. and functions.

Defoecation.

The liver—Position, structure, and functions.

The pancreas—Position, structure, and functions.

The kidneys—Position, structure, and functions.

Secretion of urine. The ureters.

The bladder—Its position and functions. Excretion.

The urine—Its composition and quantity.

The spleen—Its position and functions.

The thyroid, supra-renals.

The skin—Its structure and functions. The sweat.

The organs of special sense—The eye, nose, ear, taste.

PART II.

Subject—   General Nursing—Twelve Lectures.

Subdivisions of subject—

Qualifications of a nurse.

Distinction between the doctor's work and that of the nurse.

Hospital etiquette.

The nurse's general work—

(a) Bedmaking, management of helpless patients.
(b) Hygiene of the sick room. Ventilation, lighting, temperature, &c.
(c) Baths (different kinds), sponging.
(d) Cleansing and padding splints.
(e) Prevention of infection.

Use of clinical thermometer.

The pulse—Its variations and method of records.

Respiration—Its method of record.

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External application. Preparation of fomentations and poultices, & local application of heat and cold, cold and hot packs, hot-air bath, counter irritation, leeches, blisters.

Various methods of administering drugs, enemata, subcutaneous injections (hypodermic), saline, &c.

Lotions in common use, preparation of in varying strengths.

Hypnotics—Doses and actions of more commonly used, and methods of administration.

Poison, dosage and effects. Symptoms of poisoning by morphia, strychnine, arsenic, belladonna, alcohol, chloroform, mercury, iodoform, carbolic-acid, &c.

What to use in case of poisoning.

Drug rashes. Methods of observing symptoms, and manner of reporting same to doctor.

Dressings and their preparation.

Operation case—Preparation of patient and room.

Instruments—Their care and use.

Disinfectants and antiseptics.

Administration of foods.

Subject—   Hygiene and Public Health—Four Lectures.

Subdivisions of subject—

Air—Composition, impurities. Ventilation, amount required, natural and artificial ventilation.

Food—Classification of foods—dietaries.

Elements of sanitary engineering—Traps on drains, ventilation of drains, flushing, sanitary fittings, dampness of dwellings.

Infectious diseases—Incubation period. Quarantine.

Disinfection—Deodorants, antiseptics, disinfectants. Disinfection of person, cloths, room, and contents. Treatment of discharges.

Personal hygiene. Clothing, exercise, bathing.

The law relating to the notification of infectious diseases.

Subject—   Gynaecological Nursing—Four Lectures.

Subdivisions of subject—

Special Physiology of Female Organs of Generation.

Preparation of patients for examination—Position and preparation of patient, &c.

Douches—Vaginal, intra-uterine.

Catheterisation.

Operation—Abdominal or vaginal—Preparation for, instruments, after-treatment, complications.

Gynaecological instruments.

Signs of haemorrhage and sepsis.

Nursing of special cases—

Perinaeorrhaphy.
Vaginal and abdominal hysterectomy.
Operations for displacements.
Cystitis.
Inoperable cancer.

Appendix 2: Nursing Registration Acts, 1920 and 1922 (3)

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Beef juice.
Beef tea—Various methods.
Broths—Chicken, mutton, &c.
Fish—Filleting. Various methods of cooking.
Poultry—Method of baking and boiling.
Chops and steak—Various methods of cooking.
Custards and light puddings—Baked and boiled custard, baked rice, rice custard, tapioca pudding, &c.
Jellies—Wine and lemon.

Subject— *Housekeeping and Hospital Management.*
Subdivisions of subject—
The superintendence of the work of the servants.
The prices and relative values of all foodstuffs, household requisites, linen.
The keeping of accounts of moneys received in connection with housekeeping.
For a time personally carrying out the repairs of linen, receiving stores as they are bought or issued and giving them out day by day as required, and being responsible for their preservation in good order.
The drawing up of official reports for the Committee relating to any of the above matters.

SCHEDULE C.

Nurses Registration Act, 1920.

THE NURSES BOARD OF SOUTH AUSTRALIA.

Examination Certificate.

This is to certify that ....
of .... has passed the following examination of the Course of Training for Nurses prescribed under the Nurses Registration Act, 1920 :—

....
....

Dated this ...... day of ...... , 19 .

.....................Registrar.

PART II.—TRAINING AND EXAMINATION OF MIDWIVES.

Interpretation.

1. In this Part of these regulations—
"Prescribed course of training," or "Course of training" means the course of training which, according to these regulations, a trainee must pass through in order to become entitled to be registered as a midwife:

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Subject—*Nursing of Diseases of Organs of Special Sense, including the Eye, the Ear, the Nose, and the Throat—Four Lectures.*

Subject— *Medical Nursing—Twelve Lectures.*
Subdivisions of subject—
General symptoms of disease—Value of close observation. Temperature, rigors, pain, dyspnœa, expectoration, Hæmoptysis, state of pulse, collapse, cyance, sweating, vomiting. Hæmatemesis, diarrhœa, malaena, abdominal distension. Delirium, œdema, tenderness.
Specific fevers, characteristic—Incubation, infection, contagion, disinfection.
Emergencies—Poisoning, drowning, fainting, fits—epileptic, apoplectic, hysterical, Coma. Paralytic cases, special care of. Prevention of bed sores.
Urine testing.
Nursing of special cases—Bright's disease—Urine, pyuria, hæmaturia. Cardiac, pulmonary — Pneumonia, phthisis, bronchitis, &c. Nervous cases—Cerebral hæmorrhage, neuritis, epilepsy, mania, sciatica, meningitis, &c. Rheumatic fever, Chorea. Alcoholism. Dropsy. Gastric ulcer. Nursing and feeding of sick children, &c. Skin disease.

Subject— *Surgical Nursing—Twelve Lectures with Demonstrations.*
Subdivisions of subject—
Inflammation, suppuration, ulceration, gangrene, and septacæmia.
Healing and dressing of wounds, burns, and scalds.
Hæmorrhage and its arrest.
Bed sores—Prevention and treatment.
Fractures and splints.
Bandaging.
Operation cases—Preparation of patient in general and for special operations.
Disinfections and antiseptics.
Nursing of special cases—Tracheotomy, Jaw operations. Amputations, resections. Empyema. Tapping abdomen or chest. Operations on nose, head, tongue, throat, neck, eye, pelvic organs. Hare lip, Cleft palate. Caries of spine. Tubercular joints, &c. Management of abdominal operations. Catheterisation. Preparation of salines.

Subject— *Invalid Cookery—Six Practical Lessons.*
Subdivisions of subject—
Instruction should be given in the preparation of invalid drinks, the cooking of beef tea, broths, poultry, fish, meats, eggs, light puddings, jellies, vegetables, and fruits.
Invalid drinks—Barley water, toast water, lemonade, apple-water, gruel, white wine, whey, &c.

Resource: courtesy of Joan Durdin

Appendix 3: The assessment sheet at RAH in 1960

ROYAL ADELAIDE HOSPITAL—CONFIDENTIAL REPORT

(This form to be completed by Charge Sister and sent to Matron)

Nurse _____ Ward _____ From _____ To _____

Qualities to be observed and encouraged throughout training.

Rating	Very Good	Good	Average	Fair	Poor
1. Attention and courtesy to patients					
2. Attention and courtesy to relatives					
3. Tact and discretion					
4. Truthfulness					
5. Reliability					
6. Intelligence					
7. Keenness to learn					
8. Reception to correction					
9. Professional manner					
10. Spirit of loyalty					
11. Co-operation					
12. Generosity					
13. Punctuality					
14. Powers of observation					
15. Methodical approach					
16. Attention to detail					
17. Care of hospital property/equipment					
18. Cleanliness and tidiness in person					
19. Cleanliness and tidiness of work					

Has Nurse improved while in your Ward ? _____

Third Year Nurse

20. Does she show a sense of responsibility ? _____

21. Does she show management and organizing ability ? _____

22. Does she supervize, teach and help more junior nurses ? _____

23. Does she maintain good discipline ? _____

Remarks (all nurses—1st, 2nd and 3rd year)

_____

_____

_____

_____

Date _____   (Signed) _____   Charge Sister

Resource: courtesy of Joan Durdin

Appendix 4: The assessment sheet at RAH in 1962

Resource: courtesy of Joan Durdin

Appendix 5: The assessment sheet at RAH in 1963

ROYAL ADELAIDE HOSPITAL—CONFIDENTIAL REPORT

(This form to be completed and sent to Matron)

Name............ Ward............ From............ To............

QUALITIES TO BE OBSERVED AND ENCOURAGED THROUGHOUT TRAINING

RATING	1	2	3	4	5	Score
NURSING SKILLS	Displays little knowledge of procedures. Careless in approach	Uncertain and inclined to be slow. Lacks finer touches	Shows knowledge of procedures. Average skill	Capable and shows above average dexterity	Insight and skills are in excess of what might be expected at her level of experience	
PROFESSIONAL CONDUCT	Leaves much to be desired	Below average but has shown improvement	Occasional lapses but generally satisfactory	Conducts herself well. Maintains cordial and correct attitude	Exemplary in conduct	
CAPACITY TO ORGANIZE	Does not plan work. Always in a state of confusion	Tries to organize but needs close supervision	Able to cope with routine matters. Confused under pressure	Work well organized	Capable organizer. Resourceful and logical even under pressure	
DEPENDABILITY	Unreliable in performance of even routine tasks	Displays considerable laxity at times	Generally reliable	Consistently dependable	Can be relied on to perform work efficiently for long periods without supervision	
ATTITUDE: To self	Careless in personal appearance. Apathetic	Frequently untidy	Usually neat	Well groomed	Immaculate in appearance	
To professional authority	Resents authority	Accepts criticism but shows little improvement	Usually satisfactory attitude	Responds to suggestions. Respects authority	Exemplary conduct and helps others to appreciate need for authority	
To property	Careless of equipment and wasteful of supplies	Shows little appreciation of value of hospital property	Generally careful	Shows appreciation need for economy	Judicious in use of all equipment	
To patients	Lack of sympathy and tact	Mechanical. No thought for patients	Appears to please patients	Attentive, thoughtful. Anticipates need	Thoughtful and understanding of patients as individuals	
PUNCTUALITY	Frequently late. Incentive lacking	Tardy in work with excuses	Usually punctual	Aims to be always on time	Prompt on duty and with assignments.	

COMMENTS:

Signature............

Resource: courtesy of Joan Durdin

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Appendix 6: Nurses Board of South Australia Examination in 1965 (1)

NURSES BOARD OF SOUTH AUSTRALIA

Nurses' First Examination, August, 1965

PART (B)

Tuesday, 3rd August, 1965; from 9.00 to 11.00 a.m.

Begin each question on a separate sheet of paper.
Do not begin your answer by copying out the question.
Number all answers clearly.
The marks for each section are indicated.

1. Mrs. Elaine Jenson was admitted to the Torrens Hospital on the 4th June, 1964, under Doctor Browne. Aged 45 years, Mrs. Jenson was sent to Ward 10 and given fluids as follows:—

10.00 a.m. Tea 180 mls
11.00 a.m. Fruit juice started 300 mls
12.00 noon Soup 120 mls
1.00 p.m. Vomited clear fluid 150 mls
2.00 p.m. Voided 180 mls
3.00 p.m. Vomited undigested food 90 mls
4.00 p.m. I.V. saline started 600 mls
6.00 p.m. Voided 150 mls
7.00 p.m. Fruit juice finished 250 mls
8.00 p.m. I.V. saline finished 600 mls
10.00 p.m. Marmite 120 mls
11.00 p.m. Voided in bed
1.00 a.m. Tea 120 mls
4.00 a.m. Coffee 150 mls
6.00 a.m. Voided 120 mls

(a) Fill in and balance the accompanying fluid balance chart. (15 marks)

(b) List ten (10) important points in feeding a helpless patient. (10 marks)

2. (a) State fully and clearly what is meant by the term Complicated Fracture and give one example to illustrate your answer. (5 marks)

(b) What First-Aid treatment would you give to a person suffering a Simple Fracture of the lower leg? The accident occurred in your back yard. (10 marks)

(c) What means could be adopted by the individual to ensure the maintenance of good health? (7 marks)

(d) List any three Health Services available in South Australia. (3 marks)

3. Mrs. Browne, aged 70 years, is admitted to the Ward. Her right side is paralysed and she is in a shocked condition. She collapsed while shopping and has in her possession a large sum of money, but her main concern is for the welfare of her aged husband, who is left alone at home. Describe how you will:—

(a) Relieve her emotional distress. (5 marks)

(b) Attend to her property. (5 marks)

(c) Give the nursing care for her condition. (15 marks)

4. (a) State six important precautions a nurse should take to ensure that each patient receives his correct mixture. (6 marks)

(b) A patient has been ordered an injection of 12 mlgms of Morphia. Your stock ampoules are 15 mlgms in 1 ml (Ice).

(i) State the rule for dilution of drugs and show your calculations for diluting the above dose of Morphia. (5 marks)

(ii) Draw a 1 ml syringe and mark off the amount you would draw up. (5 marks)

(c) Show the calculations necessary to prepare 2 litres of Savlon strength 1 in 5000 from a stock solution of Savlon strength 1 in 1000. (2 marks)

(d) How many litres in 7,164 millilitres? (1 mark)

(e) How many grams in 795 milligrams? (1 mark)

(f) How many millilitres in 0.514 litres? (1 mark)

(g) Define the term "Sterilization". (2 marks)

(h) Name two articles which could be sterilized in an autoclave and state the temperature at which sterilization is achieved. (2 marks)

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Appendix 6: Nurses Board of South Australia Examination in 1965 (2)

NURSES BOARD OF SOUTH AUSTRALIA

Nurses' First Examination, November, 1965

PART (B)

Tuesday, 9th November, 1965; 9.00 to 11.00 a.m.

Begin each question on a separate sheet of paper.

Do not begin your answer by copying out the question.

Number all answers clearly.

The marks for each section are indicated.

1. You are nursing a patient confined to bed. What nursing care will you give with regard to:—

   (a) The physical and mental comfort of the patient.
   (10 marks)

   (b) The prevention of pressure sores.
   (10 marks)

   (c) The care of the mouth.
   (5 marks)

2. (a) Whilst you are visiting your grandmother, she knocks her lower leg and consequently has a haemorrhage from a *varicose vein*. State clearly *how* you would deal with this situation.
   (12 marks)

   (b) (i) What are the three fundamental responsibilities of a nurse as taught in the code of nursing ethics?
   (3 marks)

   (ii) State briefly and clearly *why* hospital etiquette demands that the nurse is—

      (a) Courteous.
      (3 marks)

      (b) Punctual.
      (2 marks)

   (iii) State five (5) points which should be observed when answering the ward telephone.
   (5 marks)

2

3. (a) (i) For what reasons may an antiphlogistine (Kaolin) poultice be applied?
   (2 marks)

   (ii) Describe how you would prepare and apply an antiphlogistine (Kaolin) poultice.
   (5 marks)

   (b) (i) What solution may be used as an enema to soften impacted faeces?
   (1 mark)

   (ii) List the equipment needed to give an evacuant enema.
   (8 marks)

   (iii) What general observations should the nurse make regarding the patient's faeces?
   (4 marks)

   (iv) List five (5) abnormalities which may be present in faeces.
   (5 marks)

4. (a) Write out a dinner menu for a patient on a high protein diet. Include the following courses:—

   Soup.
   Main course.
   Dessert.
   Drink.
   (12 marks)

   (b) State two (2) foods which are rich sources of each of the following:—

      (i) Vitamin C.
      (ii) Calcium.
      (iii) Vegetable fat.
      (iv) Vitamin D.
      (v) Iron.
      (10 marks)

   (c) State the calorie value of one gram of each of the following:—

      (i) Carbohydrate.
      (ii) Fat.
      (iii) Protein.
      (3 marks)

Resource: courtesy of Joan Durdin

Appendix 7: The curriculum guidelines from NBSA in 1966

1966 CURRICULUM GUIDELINES FOR GENERAL NURSE TRAINING IN SOUTH AUSTRALIA

This document provided schools of nursing with the guidelines which all pre-registration general nursing curricula needed to comply with to meet the Nurses Board of South Australia (NBSA) regulatory requirements. Therefore it may be assumed that any course which was approved by the NBSA met these minimum requirements. The following is a summary of the curriculum guidelines document. The complete document covers more comprehensively the content detail for each of the outlined areas.

The physical, biological and social sciences

- **Physics**- metric measurement, matter, energy, and friction, molecular motion, mechanics, heat, light, sound, electricity and magnetism, radiation,
- **Chemistry** – basic concepts, acids, bases, salts, solutions, mixtures, compounds, chemical symbols and formulae, chemical reactions, oxygen, water, electrolytes, applied biological magnetism
- Anatomy and physiology- **body as integrated whole, erect and moving body, integration and control of body, metabolism, reproduction, hormone control, fluid and electrolyte balance**
- **Nutrition**- food constituents, diets for age groups, preserving food, presenting food, special hospital diets
- **Microbiology**- organism and their environment, classification, relationships, transmission, laboratory study, prevention and treatment of microbial disease
- **Psychology**- biological and environmental influences, personality adjustments, emotions, learning, remembering, thinking, developmental psychology
- **Anthropology** study of man, culture, beliefs, morals, communication
- **Sociology** - society, individuals, groups, organisation, disorganisation, disease, personal and communal health, social aspects of disease

Fundamentals of Nursing

- **History and trends of nursing –** history of Australian nursing, organisation of nursing, professional publication
- **Professional conducts and adjustments-** behaviours and adaptation codes of conduct
- **Legal aspects communication -** injury, negligence, liability, professional confidence, consent for treatment, patient property, wills, accidents workers compensation
- **Communication -** verbal, non verbal

- **Hospital and nursing service-** hospital in the community, as a unit, health team, responsibilities as a nurse
- **The patient –** sick person, environment of patient, physical comfort, mental comfort
- **Nursing procedures -** general care, admission discharge, administration of drugs, asepsis, antisepsis, diagnostic aides procedures related to systems, communicable disease procedures, radiation procedures, dying patient, last offices,

Pharmacology
- Introduction, drug groupings, drug therapy, problems of use and abuse of drugs
- The study of disease and the integration of nursing arts and sciences
- Prevention, treatment, first aid, community

Associated special fields
- **Maternal and infant care, -** pregnancy, labour, emergency delivery, puerperium, full term infant care pre term infant care-
- **Psychiatric nursing** - mental growth and development mental health, mental illness signs and symptoms, classification, treatments, legal aspects,

Role of the Graduate

- **Principles of ward administration,** - organisation, wards and departments,
- **Principles of nursing education**- clinical instruction

Resource: Nurses Board of South Australia 1966, 'Curriculum guidelines for general nurse training in South Australia', 01/6796.

Appendix 8: The nursing competency domains in 1998

Domains

Professional/Ethical Practice

Contains the competencies that relate to legal and ethical responsibilities, including the demonstration of a satisfactory knowledge base, being accountable for practice, functioning in accordance with legislation affecting nursing, and the protection of individuals and group rights.

Reflection

Contains those competencies relating to self-appraisal, professional development of self and others and the value of research. Reflection on practice, feelings and beliefs and the consequences of these for clients was considered an important professional benchmark.

Problem Solving

Contains the competencies that relate to the assessment of patients/clients, the planning, implementation and the evaluation of care.

Enabling

Contains those competencies essential for establishing and sustaining the nurse/patient relationship. This integrates the maintenance of safety, skills in interpersonal and therapeutic relationships, and communication and the organisational skills to ensure the provision of care. It also includes those interactions with other members of the health care team.

Resource: ANCI 1998, *National Competency Standards for the Registered Nurse* Canberra ACT.

Appendix 9: The competency domains in 2006

Domains

The competencies which make up the ANMC National Competency Standards for the Registered Nurses are organised into domains.

Professional Practice

This relates to the professional, legal and ethical responsibilities which require demonstration of a satisfactory knowledge base, accountability for practice, functioning in accordance with legislation affecting nursing and health care, and the protection of individual and group rights.

Critical Thinking and Analysis

This relates to self – appraisal, professional development, and the value of evidence and research for practice. Reflecting on practice, feelings and beliefs and the consequences of these for individuals/groups is an important professional benchmark.

Provision and Coordination of Care

This domain relates to the coordination, organisation and provision of nursing care that includes the assessment of individuals /groups, planning, implementation and evaluation of care.

Collaborative and Therapeutic Practice

This relates to establishing, sustaining and concluding professional relationships with individuals/groups. This also contains those competencies that relate to the nurse understanding their contribution to the interdisciplinary health care team.

Resource: ANMC 2006, *Australian Nursing & Midwifery Council Standards: National Competency Standards for the Registered Nurse* 4th edn, ANMC, ACT.

Appendix 10: The structure of the course in 1976

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5. STRUCTURE OF THE COURSE

On the following pages the structure of the course is described. Below is a representation of the course in diagrammatic form. Pages 22-24 outline the major characteristics of each year of the course. Page 25 is a summary of the course which lists the units and unit credits.
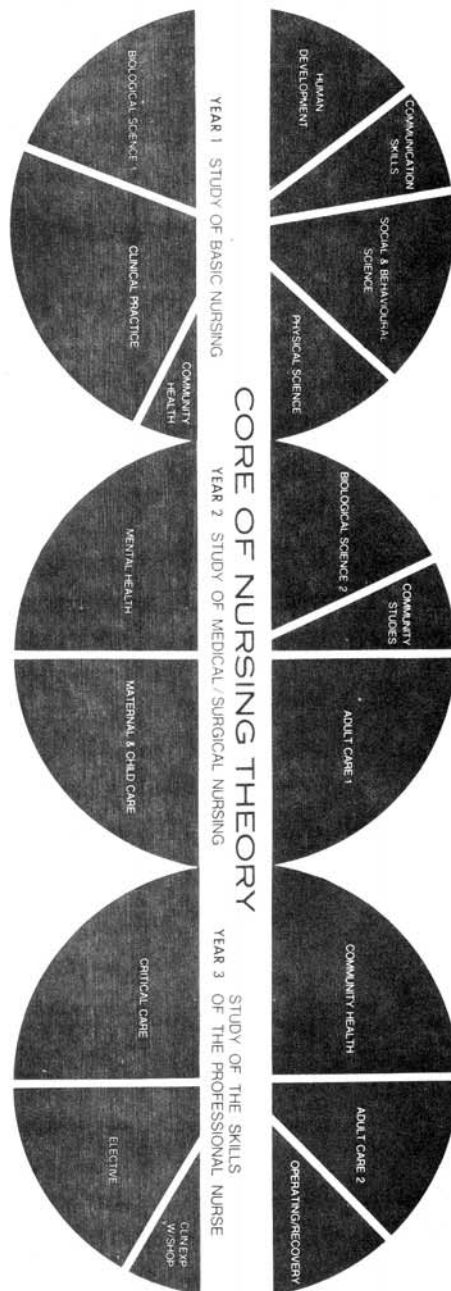
Resource: Sturt College of Advanced Education 1976, 'Proposed course Diploma of Applied Science; Submitted to the Board of Advanced Education South Australia'.

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Appendix 11: The budget of the school

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                                  - 8 -

Appendix 1

       AN ANALYSIS OF COSTS RELATIVE TO THE TRAINING OF NURSES

On the basis of costs prepared by one school of nursing in the State, the
following has been derived:
                                                            $

1.  Salaries  -  Student nurse  1st Year                   4,500
                                2nd Year                   5,500
                                3rd Year                   6,500
                                                        _____

                                                         $16,500

2.  Tutoring costs (average cost of tutor's
    salaries, visiting lecturer's fees, etc.
    over three years per student nurse)                  $ 2,358

3.  Cost of seven uniforms and cape and
    laundering costs for three years                     $   384

4.  Sundries - bus hire, lecture notes,
    films and other teaching aids, etc.                  $   538
                                                        _____
Therefore, estimated cost per student over three years   $19,770
                                                        _____

Costs not included in above:

1.  Penalty rates for weekend and night work

2.  Overheads (administration, depreciation on
    library and teaching equipment, maintenance,         Approx.
    insurance, cleaning, power and lighting;             $ 5,000+
    subsidy on board and lodging)
                                                        _____
    Estimated total cost per student over three years    $25,000
                                                        _____

Direct patient care provided during three years
= 156 weeks less 18 weeks paid holiday and 24 weeks
in 'block' = 114 weeks

Cost of service per student per week                     $   219

Cost of service of 1st Year Registered Nurse
per week (service only - $7,725 for 46 weeks)            $   168

Add penalty rates, uniforms and other overheads as for
student nurse ($1,600 p.a. approx.)
Cost per nurse per week                                  $   203

Cost of service of 5th Year Registered Nurse
(including penalty rates, uniforms and other overheads)  $   223

(Source of above figures - 1st Year Registered Nurse's Salary = $7,725 p.a;
 5th Year Registered Nurse's Salary = $9,125 p.a.  Overheads averaged at
 approximately $1,600 p.a.).

For the above hospital, between February 1973 and September 1976, there were
261 students enrolled.  46 (18%) left during 1st Year of training and 23 (9%)
subsequent to this.

Summarizing the above figures:

Average annual cost per student nurse is $8,330 for which 38 weeks work is
provided.

Average annual cost of a registered nurse (1st Year) is $9,325 for which 46
weeks work is provided.

                                                            ...9
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Resource : "Submission to the committee of enquiry into post-secondary education in South Australia" (The College of Australia, S.A. State Committee & Royal Australian Nursing Federation 1976).

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Appendix 12: The characteristics of nurses in 1960s

Deportment: A good carriage and demeanour inspires confidence in others, and gives the nurse herself a feeling of alertness, and of mental and physical well-being. Always she should stand on both feet, head erect, shoulders back, and she should cultivate the habit of giving full attention when engaged in conversation with patients, visitors or the staff.

Serenity: A considerable amount of research has been done on the deleterious effect of **noise** on the individual. One has only to observe the effect of sudden noise on a sick or sleeping patient to appreciate the seriousness of it. It behoves the nurse to create a quiet and harmonious atmosphere in her surroundings, and to eliminate all such noises as banging and creaking doors, dripping taps, rattling windows and blinds, clinking china and equipment, and noisy speech. Nurses on night duty should be particularly careful to avoid disturbing the patients by careless handling of dressing trolleys, metalware, etc. When off duty, consideration should be given to colleagues who may be resting and studying, and it is expected that nurses will be reasonably quiet in their gaiety.

Sympathy, tact and understanding of patients and their relatives, and, at the same time, a gracious dignity and decision in emergency are essential.

The spiritual relationship between a nurse and the patient, can in many cases be very important. There are many people who in the enjoyment of normal health are not greatly concerned about religious matters.

In times of illness however, or with the shadow of death touching them, they feel the need of spiritual consolation.

If a nurse has an intelligent deeply based faith, it not only gives to her personally, serenity of mind and spiritual reinforcement, but unconsciously she imparts something of the same quiet strength, and hope, to those whom she is seeking to help.

Observation—the nurse must learn what to see and the significance of what she sees. The quality of observation must be developed from the first day in hospital.

Truthfulness, accuracy and reliability—Reports must be accurate and complete, and, at the same time, helpful. Nurse must be neither an alarmist nor a cypher.

Obedience—An intelligent obedience to those in authority is essential for the care and safety of the patient.

Punctuality is important and can be cultivated by watching the clock, and by working a little ahead of time rather than a few minutes behind time.

Orderliness may be improved by punctuality, by preparation before commencing work, and by clearing up and putting away all equipment after use in the appointed place.

Economy: The practice of economy has never before been so important in hospital as it is to-day. All hospital furniture, equipment and other property is recorded on an inventory which is checked with the sister-in-charge of ward or department by the hospital authority at regular intervals during the year. It is most important that any damaged, faulty, or missing article be reported immediately.

A grave responsibility rests with the nurse to exercise economy in the use of all equipment, linen, lighting, heating, drugs and foodstuffs.

Most hospitals are maintained by public money, either in the form of patients' fees, government grants and subsidies, or charitable subscriptions. The nurse, therefore, is one of the public guardians of all hospital property, and is responsible for its care, protection and safe keeping.

Cleanliness: It has been said that cleanliness in nursing is a professional obligation. A nurse must not only be fastidiously clean, but be honourable in her cleanliness in dealing with patients and their belongings, and in her work generally.

The care of the nurse's hands is of utmost importance, for not only may she convey infection via her hands from herself to others and from patients to herself, but from one patient to another with perhaps grave results. This is a particular risk when nursing infants, children, maternity and infectious patients.

The hands should be well cared for, fingernails kept short and no jewellery or wrist watches worn on duty. Hands should be thoroughly washed with soap and running water and dried, especially before preparing and handling food and drinks, and before and after carrying out any treatment or attention for the patient.

Resource: Doherty, Sirl & Ring, 1963, 'Chapter 2: Advice to Student Nurse ', in *Modern Practical Nursing Procedures.*

Appendix 13: The Nightingale Pledge

> "I solemnly pledge myself before God and in the presence of this assembly to faithfully practice my profession of nursing. I will do all in my power to make and maintain the highest standards and practices of my profession.
>
> I will hold in confidence all personal matters committed to my keeping in the practice of my calling. I will assist the physician in his work and will devote myself to the welfare of my patients, my family, and my community.
>
> I will endeavor to fulfill my rights and privileges as a good citizen and take my share of responsibility in promoting the health and welfare of the community.
>
> I will constantly endeavor to increase my knowledge and skills in nursing and to use them wisely. I will zealously seek to nurse those who are ill wherever they may be and whenever they are in need.
>
> I will be active in assisting others in safeguarding and promoting the health and happiness of mankind."
>
> author unknown

Resource: The article from 'The Nightingale Pledge: 100 years later (McBurney & Filoromo 1994).

Appendix 14: The nursing process in 1978

APPENDIX 5 : THE NURSING PROCESS

A CONCEPTUAL FRAMEWORK FOR NURSING - THE
FOCUS AND THE NURSING PROCESS*

(FOUR STEPS)

1
ASSESSING
Needs of person
in terms of their
health/illness status

4
EVALUATING
Measuring by objective
and subjective tests the
success/failure ranking
of the nursing care plan

FOCUS
PATIENT/CLIENT/PERSON
Intellectual,
emotional, physical,
socio-economic needs

2
PLANNING
Nursing action
and level of skills
required to improve
patient's health status

3
IMPLEMENTING
Determining the degree of
professional judgement required
to successfully implement the
nursing care plan: assigning
the appropriate category
of nurse

———————————— CYCLICAL MOVEMENT
— — — — — — — — — INTERMITTENT REANALYSIS

* The Nursing Process is a dynamic one in that
there is continual cyclical movement, as well
as an opportunity to reanalyse each step.

150.

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The nursing process is illustrated diagrammatically
in the figure above.

It is shown as a dynamic process in which there is
continued cyclical movement. The functions illustrated
are:

    (i)   Assessing the nursing needs of the
            patient or client in terms of his
            health or illness status

    (ii)   Planning nursing action required to
            meet the patient's/client's needs which
            involve knowledge of nursing care
            principles

   (iii) Implementing nursing action through
            appropriate nursing procedures which
            incorporate the prescribed medical
            treatment

    (iv)   Evaluating the results of nursing action
            and on the basis of the results recorded
            and observed and the assessment of
            the effectiveness of the nursing,
            continuing or modifying nursing care.

Resource: Nurse Education and Training: Report of the Committee of Inquiry
 into Nurse Education and Training to the Tertiary Education Commission
(Committee of Inquiry into Nurse Education and Training 1978, pp. 150-1).

Appendix 15: A scope of practice decision making tool

1   Introduction

Scope of Practice of the Individual

The scope of practice of a nurse or midwife is that which they are
- **educated**
- **authorised &**
- **competent to perform**

The scope of practice of an individual nurse or midwife may be more specifically defined than the scope of the profession. To practice within the full scope of practice of the profession may require individuals updating or expanding their knowledge, skills and competence.

Scope of Practice of the Professions

The scope of nursing and midwifery practice refers to the broad framework and context of practice of the professions including
- **the range of roles**
- **functions and responsibilities &**
- **decision making capacity**

which nurses and midwives perform in the context of their practice.

Some functions within the scope of practice of the profession may be shared with other professions or other providers. Scope of nursing and midwifery practice is influenced by the setting and environment, policy, education, standards and the health needs of the population.

2　Statements for consideration in relation to scope of practice

Regulatory context

- Nurses and midwives are increasingly taking on expanded roles and activities in the interest of comprehensively addressing client needs in a safe and cost effective environment. At the same time, nurses and midwives are reclaiming roles and activities that were previously within their responsibilities. Nurses and midwives are still expected to maintain the core aspects underpinning the philosophy of care and caring. **Nursing and midwifery is not moving incrementally forward rather it is concentrically expanding.**

- Nursing and midwifery practice has moved toward broad, enabling scope of practice frameworks which support nurses and midwives as professionals to make decisions about and within the professions' scope of practice. The professions have moved away from prescriptive policy and certification of tasks and activities.

- Decision making within scope of practice needs to be structured and based on a defined framework which supports and guides nursing and midwifery practice in a contemporary and accountable manner. The **nbsa** has the mandate under the *Act* to determine this framework.

- Scope of practice decision making within a sound risk management, professional, regulatory and legal framework should be seen as an enabling process for nurses and midwives to work within their full and potential scope of practice and not merely the addition of tasks and activities.

Responsibility

- As self regulating professionals, nurses and midwives must be able to assess and articulate their own competence and scope of practice.

- Nurses and midwives should proactively lead the development of nursing and midwifery practice to meet client needs rather than reactively adopting roles through health industry transition and change.

Influences

- Historically, scope of practice decision making has often been reactive and unplanned without due consideration and support. This has resulted in decisions being made on an ad hoc basis which may vary between settings and individuals.

- Influences on scope of nursing and midwifery practice include changes in technology, legislation, community expectation, resources, collective vision of the nursing and midwifery professions themselves and work practices of other health professions and providers.

- Changes occurring within the nursing and midwifery professions include methods of delivery of care, increased specialisation, increased autonomy and accountability, emerging new health provider roles, changes in structure and funding of education, reducing resources and reduced numbers of nurses and midwives and an aging workforce.

- The scope of nursing and midwifery practice is broader than that of the individual nurse or midwife, the broadest parameters of which are set by legislation and professional standards and the individual parameters determined by organisational policy, culture and individual competence, knowledge and skill.

nursesboardsouthaustralia A Scope of Practice Decision-Making Tool　　　　　　　　5

Resource: A scope pf practice decision making tool (Nurses Board of South Australia 2006).

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