Separation. The experience of nursing education and practice in Australia 1964 – 1994: an autoethnographic study.

by

Lesley Mary Hills Siegloff

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ABSTRACT

Tension exists today about how nurses are educated in Australia. Many people believe that nurses should be trained in the hospital system while others have argued consistently for pre-registration nursing education to remain in the tertiary education sector. This thesis is focused on understanding how nursing education as we know it today unfolded and was shaped.

The thesis covers the first thirty years, 1964 to 1994, of my nursing career and draws on my experience as researcher and subject, to identify new perspectives on the separation of pre-registration nurse education from the health care sector over the period studied, specifically where it interconnected at the time of a significant and extended period of change. The way in which the thesis is presented through an autoethnographic lens has resulted in new insight into the evolution of nursing education in Australia.

The outcomes add a unique and complementary perspective to the current predominantly descriptive historical documents and literature about the development of nursing education in Australia.

The principal outcome of the study revealed that an unintentional separation occurred between the nursing education sector and the health care sector, which resulted in a siloed understanding by each of the sectors about the responsibility for the development of nurses and the profession This divided understanding ultimately impacted on the sense of belonging to a vocation that once characterised and underpinned professional nursing.

DECLARATION

"I certify that this thesis does not incorporate without acknowledgment 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"

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I would like to acknowledge my mother Eileen Hargreaves (Hills) who is now 96. She worked for 50 years as a nurse, ending an illustrious career as a director of nursing in a country town in New

South Wales where today she is still referred to as ‘Matron’. I am indebted to her insights and support throughout my long nursing journey. To my sister Christine Davies who also spent many years as a registered nurse, thank you for your ideas during the many conversations that you and I had together and with Mum about nursing - they helped me to refine my understanding of my relationship with our patients and the profession.

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CHAPTER ONE - A STORY TO SHARE

INTRODUCTION

There remains tension about how pre-registration nurses are educated in Australia today because many people still believe that they should be trained solely in the hospital system rather than through completion of a university degree-based qualification. This thesis is focused on understanding, through an autoethnographic analysis, how and why this tension has occurred.

An autoethnographic approach is used because my personal experience traversed the period of the transition from hospital-based training to higher education, firstly to Colleges of Advanced Education (CAEs) and later to the university sector. As both the subject and the researcher I have used real world experiences and personal supporting documentary evidence and literature to unpick the causes and key understandings in relation to this ongoing debate.

This thesis covers the first thirty years, 1964 to 1994, of my nursing career specifically where it interconnected with nursing education at the time of a significant and extended upheaval in nursing education in Australia. Many of the events that have occurred shaped my experience as a nurse and nurse educator. I have used my story to illustrate some of the changes that have impacted on nursing practice and ultimately nursing education. It adds a rich and informative picture to the various other histories that focus on how nursing education in Australia had changed during this period.

Following the completion of the migration to the tertiary education sector in the early 1990s many nursing histories were published. Amongst these Godden (2006), McCoppin and Gardner (1994) and Russell (1990, 2000) wrote from different perspectives about the history of the eventual complete migration of pre-registration nursing programs to the higher education sector. Others wrote histories about the hospital schools of nursing. Among them was Durdin (1999), who wrote

the story of nursing education at the Royal Adelaide Hospital for the period 1889 to 1993. Durdin (1991) and other nursing authors, including Lumby (2005), Sellers (2002), Dickenson (1993), Bennett (1996) and Parkes (1984), wrote in support of the change away from hospital-based training. These well researched and scholarly works on nursing education make an invaluable contribution to the history of nursing and nursing education in Australia. The body of work presented in the thesis, unlike many of these histories, is a personal rather than historical account in which I share experiences of the changing face of nursing education over that period.

It is now over twenty-five years since the transfer of all pre-registration nursing programs in Australia was completed and during that time the nursing profession has continued to expand the scope of the programs being offered to students who are seeking nursing registration. This includes the recent trend toward the introduction of master's level entry to the profession as evident in the work of Foster, McAllister, and O'Brien (2017).

This chapter also includes a section describing some of the contentious issues that have arisen over the transition of nurse education to the higher education sector, and which have added to the tensions that exist even today. As I thought about these criticisms I was concerned that, if there was enough of a public ground swell against higher education for pre-registration nursing programs, a move could be made without evidence to the contrary to return these programs to the health care sector. In this study I have explored the transition of pre-registration nursing education as a way of showing how the current system came about. My story is juxtaposed against multiple sources including articles from magazines, journals, text books and archival documents in which there is information about the events and issues that have shaped the history of nursing education during this time.

RESEARCH QUESTIONS

This study addresses the research questions:

How do my experiences of nursing education reflect what was occurring relative to the education of nurses for registration in Australia from 1964 to1994? What can be learnt from my experiences?

This research has been undertaken with the aims of:

- identifying what new perspectives of nursing education my personal story reveals about nursing and nursing education in Australia during the period 1964 to 1994,

- gaining an understanding of how pre-registration nursing education has been shaped over the period of my personal nursing education experience, taking into account the social, political and professional activities occurring during this time.

THE GOALS OF THE RESEARCH

The goals are to:

- explore, explain and describe the research participant's experience of nursing education in the period under study.
- to explore and describe the outcomes of the research approach of autoethnography,
- generate knowledge about nursing education in Australia in the period 1964 to 1994, through comparison and contrast of documented events and my personal experiences.

SIGNIFICANCE

It is now over forty years since the first CAE pilot undergraduate nursing programs commenced and over twenty-five years since they progressed to universities, thereby seeing the abolition of hospital-based pre-registration nursing education. Unfortunately, rather than the transition to higher education resulting in an improved opinion about nursing education in Australia today, some people have argued for a return to the apprenticeship style hospital-based education system. Among those expressing this opinion are politicians, some nurses and current nursing students and some members of the public. I was surprised by these opinions considering my own experience of a hospital-based program while learning to be a registered nurse and later as a

nurse educator, and later still, in the higher education sector as both student and educator. I was drawn to the idea of gaining a better understanding of this phenomenon.

I recognise that my story may be similar, but in some ways quite different, to that of other nurses. My story is significant because it presents a unique window into the effects that changes in nursing education had on an individual nurse.

BACKGOUND

Historically, the first hospital-based training school in Australia was opened in the Sydney Hospital by Lucy Osburn, a student of Florence Nightingale, in 1866 (Godden 2006). While not all hospital-based programs were the same there was similarity between them in that the trainees were employees of the hospital while learning their trade on the job. In the early years of hospital-based programs trainee nurses spent all of their learning time on the wards. This progressively changed to include some classroom work learning the theory relating to their clinical practice. In 1992 all nursing education that prepared nurses for registration in Australia changed to the higher education sector (Russell 2000, p. 22). This was the first year, after over one hundred years of nursing education being offered in hospitals, in which registered nursing education was offered solely in the higher education sector (Sellers 2002). However, with the transition the schools of nursing in the higher education sector needed to negotiate with hospitals and other organisations in order to use their facilities for nursing students to gain clinical experience.

My nursing education career began in 1964 when, at seventeen years of age, I commenced as a trainee nurse in a hospital-based pre-registration nursing program in a small hospital in suburban Melbourne. In September 2017 I celebrated my fiftieth anniversary since graduating as a registered nurse. My training was influenced by the legacy of the nurses who came after Florence Nightingale and Lucy Osburn (Godden 2006; Dickenson 1993; Russell 1990). I was equally

influenced by both the nursing profession's and society's view of nursing and the importance of scientific, medical, and technological knowledge of the day as described by Russell (1990), Sellers (2002), Goldsworthy, Pickhaver and Young (1984) and Jayawardena (1961).

The lobbying for the changes in nursing education has a long history which pre-dates my becoming a student nurse. At the time of my training there were many concerns regarding the way that the health care sector was changing and how this was impacting on nursing education. When discussing this era of education Dickenson (1993, p. 164) explained that:

> By the mid-1960s the nursing profession was in a state of uncertainty as continuing technological developments in health care made their training system, which had not changed substantially for a hundred years, less and less appropriate.

Since then the shift of responsibility for pre-registration nursing education from the health care sector to the higher education sector in Australia has been contentious. In the years immediately following the complete transfer to the higher education sector I became aware that many people, including some hospital trained nurses, friends and colleagues, were challenged by the change. Their concerns were not surprising because change is often contested, especially when the status quo is disrupted. In this case the status quo was that there had been a long - established tradition of hospital-based pre-registration nursing education in existence in Australia.

THE TRANSFER WAS CONTENTIOUS

As mentioned earlier in the chapter, pre-registration nursing education has been contentious since the transfer. There are many individuals and groups who have been critical of the transfer, preferring to see nurses being educated in hospitals. At the time of the transfer concerns regarding college education revolved around the perceived limited clinical experience received by students during their undergraduate program of study and the perceived lack of readiness for practice of graduates. Unfortunately, after forty years in the higher education sector, twenty-five of which have been in the university sector, this disquiet still exists.

There are also very strong opinions held by members of the public about nurses' work and education. Among the varying beliefs expressed to me is one that '*nurses just look after the patient and carry out the doctor's orders, so why should they need to learn in a university?*' Unfortunately, such opinions are based on experiences of the past and there have been many changes to the demands being made on nursing work in the ensuing years. This is evident in the opinion piece by Lumby (2005), responding to a contrary opinion published in the *Sydney Morning Herald*, stating that:

> Our system today is extremely complex and some commentators, including Dr John Graham on this page last Thursday, still yearn for the apparently simple life when women (and nurses) knew their place, when a family meant a mother and father, a traditional marriage and well behaved children.

I argue similarly that significant changes have occurred in health care in recent years and the nursing role has had to develop and change in concert with these advances. The consequence is that nurses are now working quite differently to the way in which I had on graduating in the late 1960s.

My own training had been to prepare me in a way and for a role not dissimilar to that advocated by those who saw no need for change in nurses' work and education, this being generally at odds with the way in which many people understand the nurse's role today. I believe that my nurse training experience occurred in an entirely different world or paradigm to that of today and in turn we are now preparing nurses to practice for the new paradigm. According to Kuhn (1967, p. x) the definition of a paradigm is 'universally recognised scientific achievements that for a time provide model problems and solutions to a community of participants.' Field (1989, p. 291) explained that, when arguing for change in (nursing) education, it should be '... planned rather than a reaction to internal and external pressures', continuing that the resultant learning will be influenced by '... societal changes' that '... create such stresses on both knowledge base and service component of a profession that they will cause internal pressures to develop that lead to a paradigm shift.'

Kuhn (1967, p. x) discussed the idea of a paradigm shift and espoused the view that there is the capacity for two paradigms to coexist. The significant changes to nursing education that occurred during the period under study could have resulted in the paradigm shift as predicted by Field (1989). I suggest that because of the lack of consensus about nursing education over time, some shifting and overlapping of paradigms has been ongoing. The occurrence of overlapping paradigms has resulted in two world views existing simultaneously about the way and where nurses should be educated. The first view is that the best education opportunity to become a registered nurse is in a hospital-based program and the second and alternate position is that this education should occur in the higher education sector. Both opinions have been apparent among registered nurses, students, non-nursing academics, politicians and members of the community.

In the paragraphs that follow I share some of the examples of the criticism expressed by some members of the public, students, some nurses and one prominent politician in relation to where nurses are and should be educated in the 21st century. I argue that many of these attitudes about the way that nurses are now educated in Australia are located within the old paradigm.

My experience of hospital educated nurses' attitudes and dissatisfaction with education of nurses in the higher education sector was not dissimilar to the outcomes of the research undertaken and reported by Glass (1992) in a conference presentation. This study identified the effects that tertiary nursing education was having on registered nurses who had been trained in the hospital-based system. Glass (1992) explained these results as dualisms with differing positions held between non-degree and degree nurses:

> 1a. Non-degree nurses who believe a degree isn't necessary for clinical practice and b. degree nurses dismissing this.
>
> 2a Non- degree nurses who believe degree nurses are text book nurses who think they are better than us and 2 b. degree nurses who don't believe they are better.

> 3a Non-degree nurses with hospital certificates believing they are the only nurses who know about real world of nursing and 3b degree nurses dismissing this.
>
> 4a Non-degree nurses stating that degree nurses have been 'converted' by academics who lost touch with real nursing and 4b degree nurses knowing it was their own decision to undertake a degree.

Apart from these opinions held by some registered nurses the study acknowledges that there were others, including academics, who were not convinced about the need for nurses to be educated outside the hospital. Sellers (2002, p. 157), in a study regarding the attitudes of non-nurse academics, found that some identified their belief that '... nursing is largely perceived to be nebulous, atheoretical, and subservient to the medical profession.' The study found varying views about where nursing education should be undertaken. They included both positive and negative views about nursing education in hospitals. Sellers (2002, p. 163) identified that one respondent in her study stated that 'There has been an impetus to get nursing out of hospitals because the skills acquisition area was emphasised to the detriment of other areas and there was too much repetition.'

Included among the arguments for a return to hospital training Sellers (2002, p. 163) reported that one of the five participants had offered the opinion that:

> They were better off [trained] in the hospital. The proper education can never be built up in a university. If you want religion, you go to church. If you want to be a nurse, you go to a hospital. Nurses need the real care environment that they had in the hospital. The feeling for the hospital, the culture of the hospital can only be had in the hospital.

Some responses to Seller's research were like the arguments I heard from others over the years. These arguments revolved around the idea held by many people that nursing is solely the pursuit of care in a hospital where nurses are guided by the medical officer. Sellers (2002, p. 163) had some concerns about misinformation held by some respondents, attributing this to '… a great disparity in knowledge about what nursing actually *is*.' I have also had experience of people

advocating their belief that nursing work is directed by doctors, and that they cannot understand why nurses should be educated in the higher education sector if this is the case.

In 2004, following a period of working as a director of nursing, I returned to work in a university as a senior lecturer in the school of nursing and midwifery. At this time, as well as on many occasions previously when I was working as a director of nursing, I was confronted by people who wanted me to justify why nurses weren't still being educated in hospitals.

I was approached on two occasions to speak about nursing history, once at a Probus (an organisation of retirees) meeting, and on the second occasion the local church Mothers Union. On each occasion after completing my talk about the history of nursing in Australia, which included information about education, I opened the floor for questions. It was evident from the early questions at each event that the main concern of many members of the audience, mainly elderly men and women, was that they could not understand why those nurses who they held responsible for all nursing care would need to be educated in universities. I remember a lady at one of these events, who seemed to be in her eighties, being quite angry because she told me that she had done her training in a hospital and that she was able to do all the nursing work that was expected of her. She then finished her explanation in the way in which I had heard many nurses of her era do, and that was to explain that there is no need for nurses to have a university education. She and her friends who were present continued to argue that the hospital was the best place for nursing students to learn because, according to them, '*nurses only carry out general nursing care and the orders of the doctor*.'

I was not the only nurse at that time concerned about the current understanding of members of the public about nursing education. In an opinion piece '*Nurses know their place - and it's not back in the 1960s'*, published in the *Sydney Morning Herald* in January 2005, Professor of Nursing Judy

Lumby made an argument for nurses needing a different approach to education than that which existed in the hospital-based programs of the 1960s (Lumby 2005).

The opinions of those who ascribe to the old paradigm are also reflected in the rhetoric of some first-year nursing students who I have taught in recent years. I have regularly asked new students during the first week of their studies why they had chosen to study nursing. The answers, some of which are included below, are often as diverse as the students in the class. I heard expressions such as:

> I want to work in the emergency department,
>
> I want to work with children,
>
> I needed a job and got in,
>
> I want to care for people,
>
> I really wanted to be a midwife and will try again after my first year, and,
>
> I really wanted to be a paramedic but there weren't enough places in that course.

During the ensuing conversations there was generally at least one new student in the room following in the footsteps of a family member and who doesn't understand the need to do a university course. This has usually been pre-empted by a member of their family having told them that doing a nursing degree is a waste of time. A number of these students have explained to me that they have a relative who has also told them that they would be better nurses if they were able to do their nursing studies in a hospital rather than studying in the university. Adding to this concern is the questioning about the need to study topics such as Lifespan Development, Research, Ethics, Law, Psychology and Sociology because according to these students such subjects have nothing to do with nursing.

I understand this attitude because in the past I held a similar position. My attitude changed after being exposed to a different way of learning, one in which I was valued and supported as a

student. My first experience of being a student in a college program revealed to me that the content did not focus solely on the needs of a specific hospital but rather on the complexity of patient care. The curriculum was far reaching in its endeavour to give nurses the knowledge to be able to work effectively in the continually changing world of health care where new initiatives were occurring daily. Consequently, I had an opportunity to extend my knowledge, making me feel better prepared for my role.

When engaged in conversation with students I have shared stories like those in Chapters Three and Five of this thesis. These stories are told to show the difference between what and how I learnt in the nursing program, what I found mundane and repetitive, and the contemporary curriculum designed to meet the learning needs of nurses working in an ever-changing health care system. I have also shared with students and registered nurses the feelings that I had at the completion of my hospital-based training when I had felt very inadequate because of my lack of knowledge about new and emerging scientific information and changes in medical technology and pharmacology that were becoming evident.

The arguments made by those students against doing their course in a university program are not surprising because they valued the opinion of their family members, who in many circumstances have continued to work without the higher education sector qualification being necessary.

Notwithstanding my concern about the attitudes of nursing students and some members of the public, I am more concerned about the attitude of the Australian Minister for Health who was so critical of the contemporary approach to nursing education in 2007. What I hadn't expected was to hear that the Minister for Health (Mr Abbott) had announced that he had a plan to reintroduce the "old style" hospital-based training for nurses. I had missed the original announcement from the Minister but became aware of it when I heard Keri Phillips, an Australian Broadcasting

Commission (ABC) radio interviewer, introduce two Australian nurse historians, Sioben Nelson and Judith Godden, with whom she was going to discuss nursing education. Phillips (2007) opened the interview by saying, 'The Australian Government has announced a plan to reintroduce hospital-based training for some nurses, away from the TAFEs and universities where it currently takes place.' Phillips followed this by playing a recording of the Minister's statement, which included:

> It will be based on hospital training in the old-style, because one of the real problems with nurse training in recent years is that too much of it has been in the classroom, not enough of it has been in hospitals, and it's important that nurses come out of their training program understanding patients, and ready to help from day 1.

In the following conversation between Phillips and these nurse historians, Nelson (cited in Phillips 2007) explained why in her opinion it had been important for nurse training to change in the 1970s, stating that:

> What really happened in the 1960s and this was of course gradually through the 60s and 70s, … you had the emergence of Intensive Care Units ... following breakthroughs in science, around pain and anaesthesia and the ability to stabilise patients who had massive blood loss … So what emerged was a new kind of patient … which was the critical yet viable patient. Now that kind of patient needed a highly educated nurse, and a highly experienced well-skilled nurse. So the student nursing workforce became increasingly inappropriate.

As I listened I remembered how I had previously heard similar views to that of this Minister for Health being postulated by my friend Carolyn (pseudonym) in 2005. Carolyn had been a member of the auxiliary of the hospital where I worked as the Director of Nursing during the previous year, and we were catching up over afternoon tea in the city. After some chat about the hospital I started a conversation with her about an article which I had read in the newspaper earlier that month. She, like me, had trained as a nurse in the 1960s and I thought that she might be interested in the article which had been published in the *Sydney Morning Herald* in January 2005 by Lumby.

Carolyn and I had previously had several conversations concerning the way in which nurses were currently being educated because she thought that they should still be trained in a hospital, as we

had been. I had often tried to get her to look at both sides of this situation, firstly agreeing that our education had been a good way of learning to do the role expected at that time, and then added that because of the changes in medical science, health care and technology, the way in which nurses were now required to practice was very different to that of our early nursing days. I reminded her that the transfer of nursing education had first commenced in 1974 in Victoria, where we both had trained, and in 1975 in South Australia. This was because the nursing profession at that time believed that because of the demands being placed on registered nurses, hospital-based education using students primarily as general labour force was no longer meeting the needs of the students.

While we sat in the coffee shop I produced the newspaper cutting from the *Sydney Morning Herald* so that I could show her the article written by Lumby (2005) which gave a counter argument to a return to the old days. In essence Lumby was explaining the differences in the nursing role between the 1960s and 2005. I handed the article to Carolyn and hoped that after reading the article she might better understand the reason for the changes in nursing education. In the article Lumby discussed the treatment of nursing students and patients in the past. Lumby argued that a return to the past would not solve the problems currently being experienced in the health care system by having inexperienced student nurses doing that care as had been the case in the 1960s. Lumby (2005) wrote:

> In those days - the days I trained as a nurse – nurses were seen and not heard. So were patients and so were parents… There are some who claim the complex difficulties afflicting our contemporary health-care system can be healed with a little nostalgic balm. But the patients we care for and the treatments we offer today are worlds away from those of the 1960s. And, thank God so are our values.

Carolyn was interested in what Lumby had written but still could not see a need for higher education for nurses. She continued to argue that student nurses could get all the information needed to be good nurses from a hospital program. I understood what she meant and we both

thought about what the option could be to resolve both of our concerns. This included the problems that she thought were evident with students spending less time than we did in learning hands-on patient care, and my concerns for them to have more depth of learning and less repetition of the mundane domestic tasks which had been evident in the past.

The ongoing debate about where and how our future registered nurses are educated has not been helpful with such divided opinion. None of the changes occurring between 1964 and 1994 occurred easily, particularly those in relation to the nurse education pathway. After forty to fifty years it could be that the intent of those visionary nurses who drove the idea of improving the education of students of nursing for registration and ultimately paving the way for the professional nursing role has been forgotten.

There is one fundamental reality facing nurses and the health care system. Change is inevitable. Change has been occurring continually, including in the role and expectations being placed on registered nurses who as a consequence no longer take their orders solely from the doctor. Many registered nurses today are working with differing memories of the past, and they may not see a need to be diligent about ensuring that they continue to capitalise on the potential opportunities afforded through the changing shape of health care. As Conway (2007, p. 223) explains:

> In times of significant change such as the reforms that are occurring in the Australian health sector at the moment, there is heightened potential for the identity of specific groups to become lost or to fail to capitalise on the opportunities afforded by change to establish new benchmarks for practice.

Conway believes that nurses are one such group, discussing the changing nature of the health care system and the consequent change in requirements of the registered nurse to be a practitioner in the health care arena today. Conway argues that the registered nurse of today is required to have advanced knowledge and skills and to be an active member of the interdisciplinary team. Although clear on this issue, Conway is unsure how registered nurses see their role in the contemporary

health care system. Conway (2007, p. 223) wrote that she would like to see registered nursing, '... prepared to lead the re-creation of its professional identity to be one commensurate with the expectation of contemporary health service delivery of a degree qualified profession.'

My views align with those of Conway, in that I believe that if the profession after more than forty years of higher education is to continue to advance nursing to a professional status, then the new members must continue to be educated to a level that enables them to work effectively in the contemporary health care sector, no matter where they are educated.

This study is an attempt to explore the nature of pre-registration nursing education as it has evolved and how it came to be offered in the higher education sector. It has been designed to reveal the evolution of the nursing education story for those with little knowledge of what came before the change so that they may have enough material to inform future approaches to nursing education. The following section is an introduction to the way in which the research is undertaken.

APPROACH TO THE RESEARCH

In this thesis the nature of nursing education and the changes that occurred between 1964 and 1994 are explored and outcomes and recommendations for future research are developed.

My early nursing education journey used as the foundation for the research could be considered an anthropological field trip. Murphy (1990, p. xii) states that as an anthropologist he:

> … came to the realization that my long illness … has been a kind of extended anthropological field trip, … I have sojourned in a social world no less strange to me at first than the Amazon forest.

Any embarkation on a new journey through life, such as the beginning of a new career, is like an anthropological field trip because the beginner has little knowledge of what is ahead. I commenced that journey with no understanding of what lay ahead. I was intent only on doing my nurse training so that I could become the iconic nurse of my dreams - a sister wearing the status

symbol of the uniform and the veil. I thought that I would be nursing at the bedside for the duration of my career. Like so many young women of my day I could never have predicted that I would want to engage in higher education or in teaching nursing, or that I would use my early experience as a demonstration of the past and the transition to the contemporary approach to nursing education that is in place today.

I have chosen to use autoethnography as my methodology and method because it uses the self as subject and allows me to tell my story and to juxtapose it against the events which have shaped nursing education during the period under study. This method of enquiry enables me to answer the research questions using both evocative and narrative approaches to writing my story from my own memories to address the goals of this study.

Chang (2008, p. 17), explains that '… culture refers to individual versions of group cultures that are formed, shared, retained, altered, and sometimes shed through human interaction.' Chang (2008, p. 23) also explains that '… the self is the starting point of cultural acquisition and transmission and that the individual or the self is part of that culture as an individual and as an active member, one interacting with others in the culture.' Accordingly, because of my years of learning and working as a nurse, I have membership of the culture and contend that I have had experiences that enable me to define and describe aspects of my experience of nursing education during this period.

Throughout this thesis I have drawn on remembered events which occurred, initially as a trainee nurse and then as a registered nurse, as I learnt about the changes which were occurring in nursing education and later when I became an educator and worked as an educator. Finally, my experience of becoming a nurse academic in the higher education sector in the 1990s has been described.

My stories have been written into Chapters Three and Five, having been transcribed from the Timeline database where my memories primarily as narrative describe some of the events occurring during my career. To give the reader a feeling that the stories are a true reflection of my experience I have written some of them as if I remember what was spoken at the time. These conversations are evocative and are a memory only. As Bochner (2000, p. 270) explained, when discussing the use of memory '... the goal of autoethnography is to extract meaning from experience rather than to depict experience exactly as it is lived'. I have used these memories when writing stories, acknowledging the goal of autoethnography as a way of adding richness to the story-telling and sharing my memories of what I had encountered on my journey.

I have many memories that I have recalled when reflecting on my nursing experiences. These memories are often so strong that I have a vivid visualisation of myself experiencing various activities during my training and career. When I look back over the course of my career, I can see myself in a diverse range of nursing roles; student, trained (registered) nurse, sister, matron, lecturer, director of nursing, international nursing consultant, district director of nursing, nurse researcher, senior lecturer, divisional director of nursing, executive officer/director of nursing, but always a nurse. At each stage there were other nurses and health care professionals who impacted on my journey as employees, leaders, educators, colleagues and/or mentors. During my initial training I learnt alongside the other students, as well as the tutor sisters, ward sisters, doctors and the matron of the hospital, with all involved in my education and having an impact on me as a nurse.

My mother, who was also a nurse for fifty years, played an important role during my journey, primarily as a nurse mentor. She initially paved the way for me to see that nursing was a career that I could have for life and one in which I could always continue to learn. This was evidenced during my first year of study when Mum did her midwifery training.

At each stage of my journey other nurses have been involved and have influenced me. While I have not asked them to contribute to this research I acknowledge that what I have learnt with and from them has influenced my journey and ultimately the study outcomes. I have not drawn directly on these other voices, instead drawing on literature such as archival documents, journals, reports and books to support aspects of my story. I have drawn on personal archival data to use as triggers for my memory to write the scenarios of my story. Among these data are photographs, media releases, conference proceedings, journal articles and personal notes and letters held in a scrap book from my training days.

Although my nursing story spans over fifty years this thesis does not account for all the events of the fifty years of my nursing education journey. It is not a complete history of my career. This story focuses specifically on my experience of education during the years 1964 to 1994. There is some overlap at times with my other nursing roles but only when the story is directly related to nursing education and focussing primarily on the first thirty years of that journey.

THE STRUCTURE OF THE THESIS

When developing the transcript for this thesis I called on the work of Lather and Smithies. Lather and Smithies (1997, p. xv) explain that it is an effort '... to include many voices and to offer various levels of knowing and thinking through which a reader can make their own sense.'

As the author of this thesis I have striven to build a relationship between myself and the reader and to deliver a story that can be comprehended and interpreted by the reader. The first two chapters of the thesis explain what the thesis is about. Setting the scene happens in Chapter One and in Chapter Two the methodology underpinning the research and the research method used to collect and interpret the data is described.

Chapters Three, Four and Five are constructed around the information that has emerged from the data. In Chapters Three and Five I have told many stories about my experiences and included some in-text references in support of these stories. In this thesis significant use is made of the terms narrative and story. In Chapters Three and Five stories are used to describe personal experiences, a definition of story used for these purposes is a description of past events, experiences, etc (Compact Oxford English Dictionary, 3rd edn). Narrative, which according to Compact Oxford English Dictionary, 3rd edn, is an account of connecting events was used to write the descriptions of some of the events that occurred throughout my career onto the timeline. These narratives were used as the basis for the stories that are presented in the thesis. These are in 12-point Calibri font, and long quotations from literature are in 11-point Calibri font in accordance with the Style Manual for authors, editors and printers, 6th edition, (Commonwealth of Australia 2008). There are many occasions where I have also included some of my feelings or attitudes in my story. These personal comments are indented in 12-point Segoe font with a parchment background. There are also excerpts from documents collected by me in Chapters Three, Four and Five. These have been inserted into text boxes and are represented as figures as are photographs and copies of pictures from a book by Strahan (1991) which was published by my training school.

THE CHAPTERS OVERVIEW

Chapter One - A Story to share

The first chapter is the introduction and explains why I have undertaken this research. It includes the research questions and research aims, elaborating on the significance of the study and the background to the study. A brief introduction is given to autoethnography, which is both the methodology and method, and which is used to answer the questions.

Chapter Two - Methodology and Research Method

This chapter explores the methodology and research method to be used in the thesis. The philosophical underpinnings and the important elements to be considered when undertaking a study using the researcher as the participant are explored. The chapter also describes the autoethnographic method used to answer the research questions. It describes the way in which data was collected, constructed and analysed to form the content presented in the three data chapters of the thesis. In the method consideration is given to the ethical concerns relating to the use of the self as both researcher and the only participant of the study. It explains the use of relevant literature to support the personal data obtained through the autoethnographic process of describing my nursing education journey.

Chapter Three – Enculturation

In this chapter I share stories remembered from the first three years of my nursing journey - those years of my training to become a registered nurse in a hospital-based program. During my time as a student nurse I was learning not only about how to be a nurse but also about how to become a member of the nursing culture. This involved learning the rules and regulations about how to behave as a nurse. I describe the impact that the various experiences had on me as I tried to learn how to act in the nursing world. I have also interspersed information about nursing and the role of nurse educators at that time.

Chapter Four – A Groundswell for Change

This chapter represents a bridge between Chapter Three and Chapter Five in where I have shared aspects of my nursing education experience during the years 1964 to 1994. Included among the multiple documentary sources explored and used in this chapter were documents that were obtained from archives in Melbourne and Canberra. The result has been the addition of other voices involved in the movement for change in nursing education to my voice and the supporting

references used in autoethnographic Chapters Three and Five. The content of this chapter highlights the work that was being undertaken by committed nursing professionals concerned with the level and quality of nursing education, especially during the 1970s and earlier.

Chapter Five - Transitions

This chapter relates many stories describing my journey after graduation while trying to find a place in nursing in which I felt safe to practice. It also tells the story about how I eventually changed the direction of my career. This was achieved by taking opportunities presented to me to become an educated professional nurse interested in advancing the role of the nurse. In this chapter I also share my journey of becoming a nursing educator in a new technological age and explore nursing education at the time of the transition into the higher education sector.

Chapter Six - Reflections

Here I answer the questions: *How do my experiences of pre-registration nursing education reflect what was occurring in Australian nursing education from 1964 to 1994? What can be learnt from my experiences?*

This chapter includes the outcomes of the study. Initially reflections of the experience of undertaking this study using autoethnography are made and the five major outcomes of the study are identified and discussed. These outcomes are: An echo of the Florence Nightingale Era; Unsupervised, unskilled cheap labour; Aspirational visions not shared; Two systems - professional equals or confusion; The implications of the separation are discussed. As identified, the outcomes of the study have revealed that the result of the separation has been a siloed view of the health care sector and of the higher education sector about the system responsible for the clinical placement and clinical experience of students of nursing.

This chapter also includes a discussion regarding the types of strategies that could be implemented through professional nursing organisations, the health care sector, the higher education sector and government departments to explore a way forward for nursing education that have the potential to eliminate the separation.

CHAPTER TWO - METHODOLOGY AND RESEARCH METHOD

INTRODUCTION

This chapter introduces both the methodology and research approach used in this thesis. Autoethnography as both methodology and method is used to answer the research questions: '*How do my experiences of nursing education reflect what was occurring in Australian nursing education from 1964 to 1994? What can be learnt from my experiences?*'

This research focuses predominantly on the evolution of nursing education over the first thirty-year period of the story of my journey through nursing and nursing education from 1964 to 1994, against the history and some traditions of nursing as they evolved and influenced nursing education in Australia. I have used myself as the informant/participant of the study as I share my experiences, drawing on my memory to write the stories presented in this thesis. In so doing I have explored my relationship and engagement as a member of the nursing profession and nursing education culture to assist in making cultural connections.

The methodology is explored in the first part of this chapter, drawing on the related ontological and epistemological aspects and the nature of the knowledge that can be gained through the research. A description of the autoethnography methodology is shared, prior to which an explanation is made about alternative methodologies such as historiography, narrative research, autobiography and ethnography. These were explored before the decision was made to use autoethnography as the methodology and method of this research. This is interpretive research, which involves subjectivity and values humans and their experiences. In this chapter an argument is made for me using myself as the subject. Consideration is also given to subjectivity and the related concepts of veracity and verisimilitude, truth and memory, time and place, solipsism and

reminiscence. The research method is closely related to the methodology and is described under 'The Research Method' in the second part of this chapter.

METHODOLOGY

Autoethnography is a contemporary approach to research that focuses on the experience of individuals and has its roots in ethnography using narrative and storytelling. According to Wall (2006, p. 1), autoethnography '… allows the author to write in a highly personalized style, drawing on his or her experience to extend understanding about a societal phenomenon.' It reinforces the connection between the personal and cultural as Frank (in Peterson 2014, p. 3) explained, '... culture is located in the world connecting the personal to the cultural.' In this study I have shared personal experience of nursing education juxtaposed against multiple literary sources with a focus on nursing education, making the connection between the personal and the cultural.

According to Chang (2008, p. 23) '... the self is the starting point of cultural acquisition and transmission.' Chang supports the idea of the value of the individual or the self in having a special capacity as an individual and an active member of the culture to be able to understand the cultural context when interacting with others in the culture. Suominen, Kovasin and Ketola (1977, p. 186) define culture in stating, 'Culture finds expression in people, knowledge, beliefs, convictions, morals and laws.' This definition aligns closely with Chang's position of a member of the culture having the ability to understand the culture of which it is a part. Suominen, Kovasin and Ketola (1977, p. 186) further explain that:

> Culture is closely interwoven with the values espoused by the community. Past events and the articulation of future are both reflected in culture.

Accordingly, because of my membership of the culture of nursing and nursing education through the years under study, I argue that I have had experiences that enable me to define and describe aspects of that culture in a way that can enhance the story and ultimately the understanding of

nursing education and to make comment about the future. In the opinion of Conway (2007, p. 223) 'Exploring the past and pulling ideas through to the present to inform the future can make a valuable contribution to nurses and nursing.' Autoethnography is an ideal way of achieving this. Denzin (2012, p. 87) explains '… autoethnography bring[s] the past and the future to the present allowing us to push against the present, to present pedagogies of hope.'

In the next section of the chapter the epistemological and ontological aspects relating to the research are explored as well as the nature of the knowledge that can be gained through the research.

EPISTEMOLOGICAL AND ONTOLOGICAL ASPECTS

Taylor, Kermode and Roberts (2006, pp. 580-2) explain that '… epistemology is the research of knowledge and how it is judged to be true, and ontology is the research of existence itself.' Figure 2.1 is taken from an article by Mitchell and Cody (1992) whose publications have explored the idea of nursing knowledge and human science (Cody & Mitchell 2002; Mitchell & Cody 1992). It is included to support the position that this research is about human science - a term that was coined by Dilthey, a German philosopher of the 19th Century (Mitchell & Cody 1992). According to Mitchell and Cody (1992, p. 54) 'The human sciences refer to what we would call the humanities and social sciences - studies that describe and explicate human life.'

Figure 2.1: Ontology and epistemology of human science

Ontology	Epistemology
Human beings are unitary wholes in continuous interrelationship with their dynamic, temporal, historical, cultural worlds. Human experience is pre-eminent and fundamental, and reality is the whole complex of what is experienced and	Research and practice focus on the coherent experience of the person's meanings, relations, values, patterns, and themes. Lived experience is the basic empirical datum, as gleaned from the participant's description free of comparison

elaborated in thinking, feeling, and willing.	to objective realities or predefined norms.
Human beings are intentional, free-willed beings who actively participate in life continuously.	The person's co-participation in generating knowledge of lived experience is respected, and no more fundamental reference than what is disclosed by the person is sought.
The researcher is inextricably involved with any phenomenon investigated.	The researcher seeks knowledge and understanding of lived experience and is cognizant of the other's lived reality as a unitary whole.

Source: Mitchell & Cody (1992, p. 56)

This autoethnography will give descriptions of aspects of my exploration and interpretation of my nursing and nursing education journey thus explicating the human life inherent in the research. Mitchell and Cody publishing as Cody and Mitchell (2002, p. 6) expand on their original theory by explaining that '… human science is pre-eminently concerned with uncovering and representing truths about the human world'. The epistemological concept espoused by Mitchell and Cody (1992, p. 540) that '… the researcher seeks knowledge and understanding of lived experience and is cognizant of the other's lived reality as a unitary whole' is at the core of this research approach.

As the subject of this research, I draw on the ontological concept explained by Koch (1998, p. 1188) as '… being in the world', which for the purposes of this study is the world of nursing and nursing education. According to Mitchell and Cody (1992, p. 54) 'Human beings are unitary wholes in continuous interrelationship with their dynamic, temporal, historical, cultural worlds.' In this research I have shared some of my experiences of nursing education. These experiences, while mine, did not occur in isolation of others. I have learnt from others in the profession as I have travelled on this journey. Koch (1998, p. 1188) stated that when writing personal story '…because

we stand in the world we can never escape our historical context.' My story and my connection with others' experiences helps to reinforce the historical and cultural connection.

NURSING KNOWLEDGE

Before proceeding to identify a methodology that would underpin the approach to the research I have considered the question; *What sort of knowledge can be claimed through my research outcomes?* Carper (1978, pp. 13-23; 1999, p. 12) identified four types of potential ways of knowing in nursing and nursing education, these being:

1. empirics, the science of nursing;
2. aesthetics, the art of nursing;
3. personal, the component of personal knowledge in nursing; and
4. ethics, the component of moral knowledge in nursing.

Carper (1978) considered that while these ways of knowing in nursing are separate they are also interrelated and interdependent, and that the disciplinary knowledge of nursing cannot be complete without a variety of ways of constructing it through inquiry and experience. According to Edwards (2002, p. 40) Carper claimed that '… a single form of knowledge can be judged as superior or inferior to another, judged against another form, and is sufficient for all purposes.'

In this research the knowledge will be personal and like other forms of knowledge, empirics, aesthetics and ethics, is of value to our ways of knowing about the profession. However, to support the personal and to value truthfulness of the data, other accounts of similar experiences or events are used to support the data.

Sandelowski (2004, p. 1369) acknowledges that '… generalizability of the outcomes is in the eyes of some researchers critical to the development of knowledge', stating that '… when the results of research are not generalisable, knowledge is possible.' Koch (1998, p. 1183), writing in support of story-telling as a way of including human experience into research, argues that 'Stories, when well crafted, are spurs to the imagination, and through our imaginative participation in the

created worlds, empathic forms of understanding are advanced.' Sandelowski (2004) challenges the researcher to ensure that the knowledge developed through subjective research is structured in a way that will make it transferable when shared through publication.

In this study I have used some stories of my experiences of nursing education that occurred during the first thirty years of my nursing career to generate empathic forms of understanding about the way in which nurses are now educated. The study has been designed to showcase the education process of the past and by so doing to reveal to the reader the full circumstances concerning hospital-based pre-registration nursing education and the motivation for the eventual transition to the higher education sector.

THE SEARCH FOR METHODOLOGY

Prior to deciding on the methodology for this study I explored different research methodologies that I thought may have the potential to answer the research questions. Approaches considered included historiography because the study is based on the history of nursing education, and autobiography because I was interested in sharing some of my story as data in the research. I explored narrative inquiry to ascertain whether the use of this approach would enable me to share some of the personal nurse education experience through this methodology. I also considered ethnography because it was the research approach of some of my contemporaries, including Bennett (2009) who had explored a question about nursing in the cultural context.

A review of the literature on historiography revealed two differing approaches. Furay and Salevouris (1988, p.5) described historiography as 'the study of the way history has been and is written - the history of historical writing.' According to Taylor, Kermode and Roberts (2006, p. 347), when doing historiography:

> … the researcher documents the events and trends of human activity as they have taken place over time, using primary data from participants and observers and secondary sources of data from documentary accounts and artefacts.

I have read a nursing history thesis written by Hall (2010) and recognised that although the information contained in it added to knowledge about nursing regulation in South Australia it did not draw on any autobiographical data. I did not stop at historiography but made my search wider and went on to look at autobiography.

Writing about the nature of autobiography Seidensticker (1999, p. 46) maintains that it is an account of things that happened to someone who has lived and is a '… memoir about the life of the writer.' For autobiography Berghegger (2009, p. 1) states '… everything including history revolves around the memory of self.' Autobiographical research looked like it could meet the goal of sharing my story, however I decided that it would be useful to look further at the research literature.

The third methodology explored was narrative inquiry which, according to Pinnegar and Daynes (2007, p. 5), '… begins in experiences as expressed in lived and told stories.' Pinnegar and Daynes (2007, p. 9) explain that in narrative enquiry:

> ... the narrative is both method and the phenomena of the research written by a researcher who is not the subject of the research, although the researcher and the research are in relationship with each other.

Each of the above methodologies included some elements of interest, essentially because I was interested in writing about the history of nursing education based on my personal experiences. I believed that this would include some form of narrative writing. With this in mind I continued to search the literature to explore methodologies, among them ethnography.

Ethnography is a methodology located in the interpretive paradigm. It has been undertaken by scholars of anthropology, sociology, communication studies, education, social work, and other

fields including nursing. Ethnography is evident in nursing research studies, particularly those in which nurses are interested in cultural perspectives in relation to nursing practice and experience (Bennett 2009; Foster, McAllister & O'Brien 2006; deLaine 1997). It has been defined by Reeves, Kuper and Hodges (2008, p. 337) as:

> ... the study of social interaction, behaviours and perspectives that occur within groups, teams, organisations and communities …. using observation and interview to get inside the way each group sees the world.

When describing the method of ethnography both deLaine (1997) and Reeves, Kuper and Hodges (2008) describe the ethnographer as making first-hand accounts of what they see, hear and seek to make the descriptions as objective as possible. Because I was interested in adding my personal experiences into the data I was again not completely attracted to this methodology. The journey I took to find a methodology that would be a best fit for my research was very enlightening and enhanced my understanding of several available approaches to the undertaking of research that focuses on the personal, history and culture. In the next part of the chapter I explain my decision to use autoethnography for this study.

AUTOETHNOGRAPHY

When I was considering ethnography, I remembered that early in my search to find an appropriate methodology I was looking for research text books online. As is common on search engines other text books were offered for consideration by the buyer, and consequently I saw a reference to a text book about autoethnography by Chang (2008). Before this journey I did not have any knowledge of autoethnography. I purchased the book by Chang which introduced me to the method of autoethnography. I found that autoethnography was underpinned by ethnography and uses the researcher as subject and utilises first-hand accounts of experience to make cultural interpretations. According to Reed-Danahay (1997, pp. 2-3) autoethnography '… synthesises the post-modern ethnography and the post-modern autobiography.'

This new knowledge assisted me in making the decision to use autoethnography as both methodology and method for this research. It is a distillation of life history and autobiography and, according to Denshire (2013, p. 2) '... while autoethnography contains autobiography, it goes beyond the writing of selves.' Denshire (2013) considered that the subjective narrative data in autoethnography is taken from memory combining cultural analysis and interpretation with storytelling. The narrator contributes to the culture through the personal stories documented from experiences that have familiarity to the cultural group. In essence, in autoethnography the researcher is an ethnographer who uses personal narrative as stories in the research. Unlike ethnography, the researcher in autoethnography is both the researcher and the subject under study. Chang (2008, p. 208) explains that autoethnography is '… ethnographic in its methodological orientation, cultural in its interpretive orientation, and autobiographical in its content orientation.'

Both ethnography and autoethnography benefit from cultural interpretation. While there are similarities between the two there is a significant difference in relation to the way in which data are collected. According to deLaine (1997, p. 15) the goal of ethnography is '… to achieve cultural understanding through analysis and interpretation of data gained generally through objective observation.' Dyson (2007) clarifies the ethnographer's role as being an objective observer of the culture as an outsider.

Chang (2008) identifies similarities between autoethnography and ethnography in that both seek cultural understandings and connections. Chang (2008, p. 57) explains the difference as being the way in which autoethnography approaches the making of these cultural connections, advising that for personal data in autoethnography '... critical analysis is achieved through reflexivity'. Reed-Danahay (1997, p. 3) introduces the value of personal data being used in autoethnography, stating:

> … autoethnography is the form of self-narrative that places the self within a social context. It is both a method and a text in a similar way to ethnography but, unlike the ethnographer, the autoethnographer collects personal data as a member of the culture.

Chang (2008) and Peterson (2014) write about the acceptability of subjective data in autoethnography. Chang and Peterson support the idea that the subjective data collection of autoethnography can offer novel personal insights into the study of a culture that is not possible through the objective observation of that culture that is common in ethnography. According to Spry (2001, p. 711), '… in autoethnographic methods the researcher is the epistemological and ontological nexus upon which the research process turns.'

Ellis's (2009, p. 9) description of being an autoethnographer assisted in galvanizing my decision to do autoethnographic research, when stating:

> As an autoethnographer, I am both the author and the focus of the story, the one who tells and the one who experiences, the observer and the observed…. I am the person at the intersection of the personal and the cultural, thinking and observing as an ethnographer and describing me as a story teller.

THE RESEARCHER AS SUBJECT

An examination of the way in which an individual undertakes cultural research using themselves as the subject is described in Hayano's (1983) study of himself as a poker player and the culture of the poker player using autoethnography. In his writings he clearly laid out a case for self-observation as a member of the culture. Hayano argued that anthropologists can expand their knowledge by stepping back to make observations to study their culture and the social world. When Hayano did this as the researcher he was a full and not detached member of the research team undertaking analysis of the self-observation data of his experience. Chang (2008, p. 17), is clear about one non-negotiable premise, that culture '… is inherently group-oriented and has formation and meaning through human interaction of the individual in the cultural group.'

MAKING MEANING THROUGH CULTURAL SYMBOLS

Symbolic interactionism as espoused by Mead (in Miltzer, Petras & Reynolds 1975, p. 1) '… is the interaction that takes place among the various minds and meanings that characterize human societies.' Miltzer, Petras and Reynolds (1975, p. 1) explained that Blumer, a student of Mead's, articulated Mead's views of symbolic interactionism that identified three basic premises, and these are reflective of my approach to making cultural meaning of my stories:

> Firstly, human beings act towards things on the basis of the meanings that the things have for them,
>
> Secondly, these meanings are a product of social interaction in human society,
>
> Thirdly, these meanings are modified and handled through an interpretive process that is used by each individual in dealing with the signs he/she encounters.

In this research I have made meaning from the cultural symbols identified in my stories through the journey, taking advice from Chang's (2008, p. 48) words, 'Like ethnographers, autoethnographers are expected to treat their autobiographical data with critical, analytical, and interpretive eyes to detect cultural undertones of what is recalled, observed and told.'

Ellis and Bochner (2000, p. 737) support the use of personal narrative drawn from memory of events and believe that the narrator contributes to the culture through the documentation of '… concrete details of a life' that reflect similar experiences to the cultural group. The contribution of this research to nursing education knowledge is made through the process of interpretation of my stories as I have remembered them. The documents and articles that have been used to support my story are used to make meaning, using the 'signs' from these data.

While acknowledging the value of the story written from the memory of an individual in autoethnography Denzin (2014, p. 70), like Bochner (2000, p. 270), recognises that memory is fallible. Bochner (2000, p. 270), when discussing fallibility of the memory, acknowledges that '… the goal of autoethnography is to extract meaning from experience rather than to depict

experience exactly as it is lived.' Bochner's (2000) opinion is that the autoethnography method uses very personal narratives of experience, the analysis of which has the potential to extract meaning from experience of the personal and thereby to give it cultural meaning.

VERACITY

Developing outcomes of the research when the researcher is also the subject can bring with it the concern about subjectivity of the data and ultimately, according to Taylor, Kermode and Roberts (2011, p. 102), the ability of the research outcomes to have validity and '… allow accurate conclusions and generalisability of the results.' In the opinion of Taylor, Kermode and Roberts (2011, p. 102), when describing varying approaches to research, validity and generalisability are usually applied in the positivist methodologies and are concerned with truth and generalisability and the capacity for the '… outcome of the design and data to allow accurate conclusions.'

I learnt, like many of my contemporaries, that good research should be able to be proven to be valid and, if it is not, the information gained does not add to knowledge. Wall (2006, p. 2) maintained that her early knowledge of research was that 'Real science is quantitative, experimental and understood by only an elite few', and essentially that any other approach to research is not good research. Since those early beginnings of learning about research, like Wall (2006, p. 2) who has also undertaken an autoethnographic study, I have learnt about alternative ways of doing research such as those espoused by Koch (1998), Ellis and Bochner (2000), Holt (2003), Denzin (2014) and Peterson (2014). These are in the qualitative paradigm and are concerned with human experience valuing personal stories in research, and which argue for an alternative to proving the validity of the research outcomes.

Rather than addressing a concern with an argument about conformity in the way in which validity and reliability are proven, Yardley (2016, pp. 295-6) writes that '… difference in the

epistemological assumptions and aims of qualitative and scientific psychological traditions necessitates quite different approaches to demonstrating the value and validity of research.' Yardley (2016, p. 295) elaborates that:

> Scientific psychology relies on measures of psychosocial processes that can be shown to be independent of their context - for example, assessments of constructs and relationships that can be reliably quantified by different researchers in different people and contexts at different time-points. In contrast, qualitative psychology seeks to investigate how psychosocial processes are shaped by all the people, activities and understandings that make up their ever-changing context (including the research context).

Although Yardley (2016) focuses on approaches to psychology, the same principles can be applied when addressing the research approaches for exploring the personal experience of nursing education. I draw on this argument to support a difference in epistemological assumptions between interpretive and positivist research, necessitating '… quite different approaches to demonstrating value and validity' when using autoethnography to research nursing education Yardley (2016, p. 295), Denzin (2014) and Ellis and Bochner (2000) are authors who accept that there is a place for validity in research, however they argued that in autoethnography, rather than aspiring to validity of the outcomes, the researchers seek acceptance that their story has veracity and therefore verisimilitude.

SEEKING VERISIMILITUDE

> Verisimilitude: the appearance of being true or real.
>
> (Compact Oxford English Dictionary, 3rd edn)

Chang (2008, p. 66) has written that '… where you position yourself in your research will affect your research design' and explains that there is value in using the self as the subject, adding that there is also value in using information from other sources, including other informants, in autoethnographic research. In doing so Chang identified three ways in which one might use others in an autoethnographic research. When describing the first approach Chang (2008, p. 66) explains 'The life of self is the primary focus of inquiry and others are explored only in auxiliary

relationships with self.’ In the second approach Chang (2008, p. 65) explains that ‘… you may decide to investigate a certain life experience of yours but, instead of studying only yourself, you include others with similar experiences as co-participants in the research.’ In the third approach, the ‘self’ is the catalyst of the story of others. Chang (2008, p. 66) gives an example of the third approach in which researchers studied their parents, however is less interested in this approach where a strong emphasis on the preferred use of self as subject cannot be seen. The first approach aligns most closely with the way in which this research addresses the self as subject. Other subjects in this research are represented through the literature and archival material similar to Muncey’s research approach in which she used herself as the subject and researcher. Muncey’s 2005 publication ‘Doing Autoethnography’ described how the self could be studied using this method, including in the work her story about aspects of her personal and nursing life in England. In the description of the research the use of artefacts to assist the story telling was explained. In support of using personal experience in research Muncey (2005, p. 1) argued ‘… individual identity is sufficiently worthy of research and more than just a deviant case.’

There have been arguments made against autoethnography that have their genesis in the personal nature of the approach that privileges the self as both researcher and researched, resulting in the research outcomes being considered invalid and not generalisable (Chang 2008). In the opinion of Denzin (2014, p. 14) and Bochner (2000, p. 751), when verisimilitude is evident in writing it has the capacity ‘… to evoke in readers a feeling that the experience described is lifelike, believable and possible.’ Denzin (2014, p. 13) also maintains that ‘A truthful fiction (narrative) is faithful to facticities and facts and creates verisimilitude.’ Therefore, a well-crafted and imaginative story could be considered as having veracity and verisimilitude.

As the subject and writer of the stories included in this research I acknowledge that verisimilitude is the appearance of truth and not necessarily truth itself. I do however seek to enhance

verisimilitude of the stories by using multiple sources juxtaposing personal memory against literary sources in the study as stories

TRUTH, TIME AND MEMORY IN PERSONAL NARRATIVE

Personal narrative and memory are important epistemological concepts and truth and time are important ontological concepts in this research. Truth is acknowledged as being relative and context dependant and as Keightley (2010, p. 56) espoused '… memory is the process of making sense of time and the experience of it.'

Narrative serves to illustrate the lives of people in society and is penned by the owners of stories. It has several meanings according to Clandinin (2007, p. 7), who stated that:

> ... the term narrative is now everything to anyone and when someone speaks or writes spontaneously whether a news editor or research expert the outcome is generally described as narrative, however all talk and text is not narrative.

Freeman provides a view of personal narrative. This description helped me to understand the nature of narrative in research and its connection to cultural understanding as explained by Freeman (cited in Atkinson 2007, p. 226):

> First person narratives are an effective way of gaining an understanding of how the self evolves over time. Through the self-narrative process the researcher can secure useful information and come to a desired understanding of the self as a meaning maker with a place in society, culture and history.

As well as personal narrative, self-narration is sometimes used to describe autobiographical story-telling. Self-narration sometimes produces written narratives. These self-narratives are written by those who are engaging only themselves, drawing on memories. In this research these terms are used interchangeably. Darian-Smith and Hamilton (1994, p. 1), encourage the historian to use personal memory when writing about their history, explaining that 'Memories link us to place, to time and to nation: they enable us to place value on our individual and our social experiences and they enable us to inhabit our country.'

The argument relating to the truth of memory in autobiography is presented as a legitimate way of considering memory in this research. Berghegger (2009), who uses the term memory-narrative in relation to writing memory when doing autobiography, argues that because our memories are based on recall they are not necessarily untrue.

In Berghegger's (2009, p. 1) opinion 'The subjectification of history may be happening in memory-narrative, but it does not make it untrue', and makes the point that '... truth itself is subjective.' Berghegger (2009, p. 1) continues, '… when we hear stories about 'an event 'and if the memory-narrative corresponds with our preconceived notions of what it must be like to be involved … then we believe the story.' However, in doing so I am also aware that I could risk falling into the trap of restructuring history through my memory- narrative. As Berghegger (2009, p. 1) argues 'The restructuring of history to suit the aims of the author is already happening through his memories as the memory-narrative is being constructed and edited and reconstructed.' Therefore, I have sought to reduce this possibility by drawing on information from my collection of personal documents that I have kept over the years, including a scrapbook from my training days. I have drawn on other people's accounts taken from the literature of similar issues to those that I have experienced, and these have supplemented and been interwoven with my experience.

MEMORY - TIME AND PLACE

Human science research, including methods employing autobiography, is concerned about the ability of memories to change depending on the time and place, the capacity to reflect the features of the time and place, and the circumstance in which the persons find themselves reminiscing (talking about). It engenders belief that the remembered event occurred. Saint Augustine (1961, pp. 268–9), an early writer about time and its relationship to memory, articulated that '... time can only be measured while it is passing'. There is nevertheless time past and time future. Past and future, Augustine postulates, can only be thought of '… as present; past

must be identified with memory and future with expectation, with memory and expectation being both present facts'. There are according to Augustine (1961, pp. 268–9) three times, '… a present of things past, a present of things present and a present of things future'. Augustine (1991, pp. 268-9) goes on to explain that '... the present of past things is memory; the present of present things is direct perception; the present of future things is expectation'. Ely and Mercurio (2011, p. 376) also explored the concept of time when they undertook a study in which they '… explore the relationship between time perspective and autobiographical memory'. They drew on the work of Conway, Singer and Tagini (cited in Ely & Mercurio 2011, p. 376) who maintained that 'Autobiographical memory is an essential component of temporal sense of self, a self that has a past, lives in the present, and foresees the future'. When discussing the outcomes of their research Ely and Mercurio (2011, pp. 391-2) elaborated that:

> Many of our predictions regarding the relationship between time perspectives and phenomenological and meta-cognitive aspects of autobiographical memory were supported. An orientation to time that encompasses positive feelings about the past was associated with more emotionally intense, sensorally rich, and linguistically coherent memories. Along with a nostalgic perspective, a PP (past positive) orientation was also associated with a tendency to foster connections between the past and present though more frequent reminiscing (*talk about*) as well as with the belief that remembered events actually occurred.

In this study the memory of past things relating to experiences have been drawn on in the present using perception with a view to analysing these experiences to make recommendations for the future. In so doing Augustine's (1961, pp. 268–9) assumptions that '… neither the past nor the future exist in the present, yet there is expectation in the present of future things', are understood.

REMINISCENCE

When one writes about experience, drawing from past memory to remember our lives and experience, reminiscences occur. Prior to writing the stories that have been used as data in Chapters Three and Five of the thesis, significant time had been spent in drawing on my memory

reminiscing about past events. As can be seen in the data significant time and space in the thesis has been given to the story of being a student of nursing and the early years of my nursing education experience. The story commences when I was sixteen years of age and continues throughout my young adulthood, finishing in 1994.

In the literature Bohn and Berntsen (2011) state that reminiscence of past events made by people over forty years of age are likely to be focused on memories of young adulthood from fifteen to thirty years of age. They explain that this has been called 'the reminiscence bump' and is '… considered a hallmark of autobiographical memory research and is featured in almost all textbook accounts of the field' (Bohn and Berntsen 2011, p. 197). In this thesis Chapter Three covers the reminiscences of my memories of my story when I was between seventeen and twenty years of age and these are firmly encompassed within the years of the reminiscence bump. As a person well over forty years of age there have been times when I have had to defend my position to people questioning the methodology that I have chosen to use for this thesis. They were not convinced that I would be able to recall events after all this time. When I was recalling my experiences of that period I found that some of my memories were triggered by some of the documents pertaining to past events. My memories were very strong, and I could almost see the events that came to mind.

My argument for acceptance of the use of memory is reflective of that of Ellis, Adams and Bochner (2011) when they defended memory in the use of the story of one person over the memory in the story of another, arguing that people will have different stories to tell about the same event. Ellis and Bochner (2000, p. 270) remind readers that when talking about writing and memory in autoethnography we are not giving chapter and verse of our life - we are storying our life. Camden-Pratt (cited in Kidd 2009, p. 86) defines the term 're-membering', explaining it as '…

pulling together of scattered aspects of the past self(s) to re-present a coherent story that meets the needs of today.'

In autoethnography literature the difference between truth and truthfulness is also of concern. Medford (2006, p. 853) explains the concept of slippage in this context:

> There is slippage between truth (or our experience of reality) and truthfulness because sometimes it seems appropriate - even necessary - to abbreviate, edit, or otherwise modify our life stories in our writing.

Autoethnographic scholars such as Medford recognise that writing the truth, or the objective account of reality, is not possible. There is always slippage whenever we try to recall and write according to Medford (2006), acknowledging that when writing from memory we do not always remember the exact words that were spoken. The background details may seem irrelevant, or maybe we honour someone's request not to be included in our writing. Words have the potential to add value. Medford (2006, p. 853) also discusses 'mindful slippage' when stating that 'The difference between what we know (and what we cannot remember) and what we write is mindful slippage.'

Knowing that I cannot vouch for their literal accuracy and recognising the potential for memory slippage I have made every effort to ensure that I have been truthful about the memories that I have written about my experiences.

In the next section an explanation is given regarding how I, as researcher, avoided solipsism.

AVOIDING SOLIPSISM

> Solipsism: the view that the self is all that can be known to exist.
>
> (Compact Oxford English Dictionary, 3rd edn)

When I considered the way in which my memories would shape the personal narrative used in the stories of this research I was conscious of the potential for solipsism because I was not involving

other informants in the research. However, I acknowledge that I did not learn about my culture of nursing education alone. I learnt about the culture through my engagement with others in my community of practice (Chang 2008; Street 1992). Consequently, I looked for a way to ensure that my personal narrative was not the only data being used to reduce the risk of being a solipsistic researcher.

There are those who produce autoethnography who are considered to have concentrated too long on themselves to the detriment of being able to make cultural connections, resulting in research outcomes that may not assist in the development of new knowledge. Oleson (2005) warns that they can be considered as being egocentric or solipsistic. By way of discouraging this outcome Chang (2008, p. 45) warns researchers to avoid '… excessive focus on the self in isolation of others and overemphasis on narration rather than analysis and cultural interpretation.'

There are researchers who have used autoethnography and have included other informants who have had similar experiences to themselves to read and support their data. They include Foster, McAllister and O'Brien (2006) and Chang (2008). There are other nurse researchers including Muncey (2005; 2006) who used only themselves as the informant in their autoethnographic research. Muncey (2005) wrote stories by drawing on literature and artefacts from the period, arguing that individual identity is significantly worthy of research without drawing on other informants. However, as with many methodological debates, this question will continue to be addressed in the research literature.

THE RESEARCH METHOD

In this part of the chapter the autoethnographic method that I have used to answer the questions of this thesis is explained.

There are five stages in the approach to the method, Stage 1. Getting Ready; Stage 2. Collecting data; Stage 3. Documenting the data; Stage 4. Analysing and interpreting data; Stage 5. Writing autoethnography. The approach to the collection of the data in Stage 2 includes a decision about what type of database to use. I developed a '*Timeline*' as the database.

STAGE 1 – GETTING READY

Using the self as an autoethnographic exemplar

In the early days of developing the method the discussions held between myself and my supervisors revolved around a concern that the work may turn into a self-indulgent story written about myself by myself. There existed a concern that I could be considered self-indulgent and add nothing new to the discussion about the transfer in Australia of pre-registration nursing education to the higher education sector from the original hospital-based training programs.

In the first instance, when developing the approach to the study, I considered approaching others in order to use them as critical friends for the study. I was conscious that whomever I used as critical friends would need to have had some experiences of nursing similar to mine, even if not necessarily at the same place where I had experienced the events under discussion. I recognised that their memory would be as historical as mine. I understood also that, whatever the case, critical friends will often have had different experiences to my own, while at other times they may have had similar experiences but have interpreted them in a different way. I believed that this situation would not necessarily strengthen the explication of the story. During these considerations, I was fortunate to be able to spend time at a meeting in the United States of America (USA) with Heewon Chang, author of Chang (2008) 'Autoethnographic Method'. Because I was interested in learning more about the method and was travelling to the USA I had written to her to ask if I could have a meeting with her about her method and my research. She was very obliging and suggested that we meet at her office in the university. During this meeting on 11th

November 2011 Heewon Chang and I discussed the idea of using critical friends when doing autoethnography. She explained that she held no strong opinion on the matter but advised me that my story and approach would have strength in either case, with or without the use of critical friends. I again had the opportunity to meet and speak with Heewon Chang on 23rd October 2012. We spent that time discussing issues around the complexity of autoethnography and the variety of ways in which authors had approached the research process. She was very supportive and gracious with her time. At this time, we continued our discussions about using the literature to juxtapose against my story rather than using critical friends in the study. Heewon Chang believed that this could be an acceptable way forward for my study.

We discussed the view that even if I did use critical friends to read my material they would not be able to validate or strengthen the material because, even though they may have had experiences similar to mine, their story would be different to mine. Ultimately, I kept to my original plan and decided that I would use my own self data and look at the literature available to support, contrast or compare with what was occurring in pre-registration nursing education at specific times, thus seeking verisimilitude of my story while avoiding solipsism.

Ethical considerations

Considerable time was spent exploring the need to seek ethics approval for this thesis. An exploration of the National Statement on Ethical Conduct in Human Research (National Health and Medical Research Council and Australian Research Council 2015) was made to ensure that the definition of human research did not apply to this research. Consequently, ethics approval has not been sought, however consideration has been given to the need to ensure that those who I have observed during my journey and have included in the thesis have had their rights protected. In the next part an explanation is given regarding the opinion that ethics approval was not required.

Throughout my career much of my story has intersected other nursing stories and the experiences of other nurses. The study uses primary data, my personal documents and memory, collected throughout my career and secondary data from nursing and other related public and archival documents. Data gained directly from other human informants were not used in the study. Some of the data has however been gained through the observation of others and interaction with others during my journey. Ostensibly I have been gaining data without gaining permission from those I have observed over the many years of my journey. Equally and importantly at the time of making these observations I was not engaging in this research. The research occurred much later.

When discussing the ethics of observing others without informing them Hayano (1983, p. 157) stated that '... the social scientist cannot wear a warning sign: You may be the subject of scientific observation.' He went on to write about the issues of the ethics of the inclusion of information about observing the other when you are personally embedded in the research. Hayano (1983, p. 157) wrote:

> The mutual influence of the researcher and his subjects is firmly implanted in the ethics of participation and penetration. There is no doubt that over the poker table I influenced others and they in turn were affected by me.

Considering the views of Hayano (1983) and Roberts (cited in Taylor, Kermode & Roberts 2006, p. 104), which explain the need to ensure that others in the research are not harmed, I explored the implications of inadvertent exposure of others who are not direct participants in the study but who assist in informing the study. This is discussed in the next section under *Ensuring privacy of others*.

Ensuring privacy of others

My data were collected over time and, while of a general nature, were converted as narrative onto a timeline during the data collection period.

I have been influenced often by my experience of working with and talking to other nurses and nurse educators during my career. The events in which I have engaged in my journey have also included others. In the writing I have chosen to maintain the privacy of others when an event may have arisen that is not written up in a public record or published in the media or literature. On other occasions such as with engagements with my mentor in the South Australian hospital located in Chapter Five, I have used a pseudonym in place of their real names. The reference to the tutor of my training school, which is made in Chapter Three, is an example of her being identifiable through public record, however I have not attributed other than positional identity in the text. This positional identity is available on the public record and I have sought to give facts and not opinion in this case.

In other accounts I have maintained privacy by making a general statement about the dean, nurses, doctors or members of the public, using third person attribution and not naming the person involved. Every effort has been made to de-identify any data about individuals located in my stories. On those occasions when I have also used public record data individuals are identified and referenced in the text.

STAGE 2. COLLECTING DATA

Development of the Timeline table

I designed a Timeline in which to input the first iteration of data for the thesis.

I divided the timeline into five sections; the time in decades called Work life/ Context; My story (personal memory data as narrative); Nursing activities/issues and changes; References to related nursing literature; Research, political action and policy development; Science and technology, as shown at Figure 2.2

Figure 2.2 Timeline database framework

Timeline data base 1964 to 1994				
Work life/ Context	**My story (personal memory data as narrative)**	**Nursing activities/issues and changes; References to related nursing literature**	**Research, political action and policy developmen t**	**Science and technology**

Collecting personal memory data

Thinking back over my past by reminiscing - I drew on my memories of the nursing experiences, specifically those relating to nursing education.

Personal Scrapbook and Documents - While I was training to be a registered nurse from 1964 to 1967 I kept a scrapbook into which I pasted photographs, letters and brochures and other memorabilia of activities in which I had engaged throughout my training. After graduation I also got into the habit of collecting documents and letters that I thought were important to my journey through my nursing career. These are part of my personal archive. Some of these data have been invaluable to the development of the thesis. Some have acted as triggers to my memory, enabling me to reminisce about my experiences. The scrapbook has been referenced many times throughout Chapter Three.

Using multiple data sources

To ensure the veracity of my stories and verisimilitude in the research, several sources of data have been used to juxtapose the personal memory narrative developed as story in Chapters Three and Five against literature such as text, media resources, archival material and other historical sources. They have been used in this way to assist me as the researcher and subject, to be able to identify those events of similarity or influence impacting on pre-registration nursing education and the nursing culture, and then to align the related data with my experiences. Ellingson (2009) describes the practice of using multiple data sources as crystallization. Richardson and St Pierre

(2000, p. 963) also wrote about crystallization, explaining that '… a crystal combines symmetry and substance with an infinite variety of shapes, substances, transmutation, multi-dimensions, and angles of approach … what we see depends upon our angle of repose.' Tracy (2010, p. 844) also describes crystallization, stating that it is used '… not to provide researchers with a more valid singular truth, but to open up a more complex, in-depth, but thoroughly partial, understanding of the issue.'

When I began writing narrative on the Timeline I recalled from events I had experienced during my engagement with nursing education I wrote from memory. At times the memories were triggered by materials that are in my personal archive. These memories have been like a light into the past and have in some instances assisted me in recalling events that I have written as narrative onto the Timeline in readiness for the stories that are in the thematic chapters of this thesis.

Acknowledging that autoethnography is a means of explicitly linking concepts from the literature to narrated personal experience, I have overlaid the textual data developed from my personal sources with the related data that I had sourced through the literature and from media clippings, archival materials and other documents. This approach could be explained as the crystallization that Ellingson (2009) described. The added benefit of the use of all these sources is that these data have also assisted in triggering my reminiscence and memories. Examples of sources used in this thesis are:

- Contextual artefacts - magazines and historical archival documents and published stories of other nurses that have reflected on nursing and nurse education over the period under study in Australia,
- Official documents - political and legislative documents that have impacted on nursing and nurse education over the period under study in Australia,

- Literature - nurse academics' and historians' publications and political documents that relate to my story and that have impacted on nursing over these thirty years of nursing education in Australia. Some journal publications and text books that bear a relationship to my journey and that have told the story of nursing prior to 1964 and since have been referred to so that the story is contextualised.

In addition to my personally collected material I accessed multiple data sources from a variety of archives, libraries and online databases. Personal data are primary sources and archival material are secondary sources. I travelled to Melbourne and Canberra in search of archival material. I searched for material in my training hospital document store room as well as the National and Victorian archives and libraries including the South Australian Library, and the Flinders University Library located at the Sturt Campus. Sturt Campus is the building where the South Australian College of Advanced Education (SACAE) was located in the 1970s and at which the first South Australian tertiary nursing education program was run. I have written the story of locating and acquiring the documents from my training hospital as Appendix 1, titled '*Breaking open the documents stored in the attic of the hospital-July 2010*'.

Inputting data into the 'Timeline' database

Developing the database as a timeline and entering narrative as the data has been a process of uncovering how my nursing education story unfolded by drawing on events in which I had engaged over the thirty-year period of my study.

Columns One and Two

In Column One I commenced by identifying my employment history as taken from my curriculum vitae. The locations of my employment are listed alongside dates representing approximate decades, and work roles and responsibilities were entered.

In Column Two I wrote personal memory data of events as narrative which I remembered as having occurred during that period alongside the relevant decade, and places of employment. These memories were often evocative and have informed the direction of the study. The explanation about the development of the data is as follows.

The landmarks in my curriculum vitae were of assistance as I extracted excerpts from these data and wrote and made notes of my memories. An iterative process occurred as I wrote into the first and second columns. I drew on my memory, reminiscing about the events and then reflected on those that I wanted to include in the data base. In the first instance many of the narratives were similar so it was important to keep going through and writing and rewriting reflexively, thereby enabling the narrative that would be transposed as story into the thesis to emerge. After writing each event I sought out other data in literary sources to see whether there were supportive or similar activities, events or issues that might be of value to my story. I documented the outcomes as data and information that was subsequently entered into the third, fourth and fifth columns.

Column Three

This column is populated with reference material relating to policies, reports and journal articles about nursing that were being published, reported and debated at times throughout my nursing journey. I used fragments of data and signs from the second column to search the literature to build this resource.

Columns Four and Five

Decisions about the information to be used to populate Columns Four and Five were made also by exploring the related signs from Column Two. Column Four was populated with reference material from archive materials, media and journal literature relating to research, political action

and policy development. Column five details some technological advances and treatment changes that have had an impact on some of my experiences.

After inputting personal bits of memory into the timeline they were expanded, written up and transcribed into Chapters Three, Four and Five.

STAGE 3. DOCUMENTING THE DATA

Writing the data in and across the columns

I read and reflected on what I had written in the first and second columns and then moved to the third, fourth and fifth columns and asked myself what was happening at that time. What was the media saying about nursing at that time or in relation to the event? What was written about that related to my memories? Were there other events being documented about nursing that would help to inform these data? I continually asked myself questions such as: 'What was happening at this time in relationship to changes in the education of nurses?' 'What led nursing into higher education?' 'Who was working in the back ground to influence government to see the need for nurses to have a change in education?' 'What were others writing about at that time?' I then searched the nursing, nursing education and related literature to find what others were writing about the issue at that time and entered these references into my timeline. In this dynamic process I moved backwards and forwards between the data columns, building the ideas. I undertook several searches for resources by using keywords to identify journal articles and other data sources such as those located in the national and state archives. I have subsequently found that data collection and generation through writing is itself a personal and subjective experience and that to some extent this takes on a life of its own.

Identifying and collating similar data located on the Timeline

I worked through the narrative data on the timeline in Column Two, identifying the fragments and signs and sorting them by similarity. Ultimately two main ideas formed, (1) Educated to become a

nurse, and (2) The years post registration. I chose the narratives that best fitted under these headings. I copied the narratives of the two periods from the Timeline and pasted them into a word document. These narratives formed the nucleus of the stories for the two data chapters that were originally Chapters Three and Four of this thesis and have been called Enculturation and Transitions respectively. As I worked through the data and documentation I became aware that, rather than have only two chapters that focus on the story of nursing education, I would include a new Chapter Four and have Chapter Five become Transitions. The new Chapter Four represents a bridge between Chapters Three and Five. In this chapter I have shared documented highlights gained mostly through letters located in the various archives that I visited, and which revealed the work that was undertaken by committed nursing professionals concerned with the level and quality of nursing education in Australia, especially that which was evident during the 1970s and earlier.

Integrating the data from multiple sources

I drew on the data extracted from the multiple sources and integrated aspects of these data as they related to the stories and events that were now located in the word document. The major ideas were built using all relevant sources to inform each of the chapters and to enable the development of the final discussion in Chapter Six of the thesis.

STAGE 4. ANALYSING AND INTERPRETING DATA,

Using the self - making cultural meaning

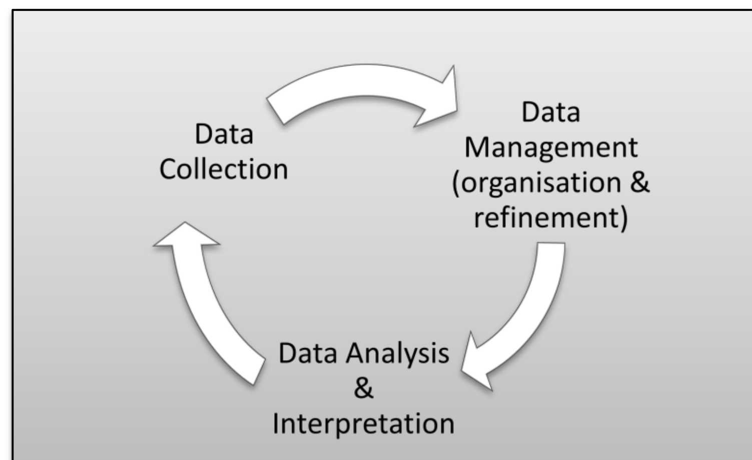
As an active participant within the culture of nursing and nursing education my memories and the narratives that make up my journey through nursing are used as data for inclusion in this research, making cultural connection through the data.

Autoethnography supports the writing of the story of one person's lived experience through a larger cultural lens. Culture is explored through this lens by taking into account the role of the self as researcher and as a member of the cultural context

Chang (2008, p. 128) explains that cultural data analysis '… transforms bits of autobiographical data into culturally meaningful and sensible text.' Data analysis occurred throughout the writing of the textual story as I worked thoughtfully through the writing and identified stories that were emerging.

Analysis and interpretation continually occur during the process of writing autoethnography. Chang (2008, p. 121) explains that '… autoethnographic research process is not linear, … research steps overlap, sometimes returning you to previous steps, … one activity informs and modifies another.' Figure 2.3 is a diagram developed by Chang (2008, p. 122) showing the interrelationship between the related data management activities, explaining that this data management process facilitates data analysis and interpretation.

Figure 2.3: Interrelationship between data management activities



Source: Chang (2008, p. 122)

STAGE 5. WRITING AUTOETHNOGRAPHY

Writing narrative from the data as story

The narrative located in Column Two of the Timetable is used, drawing on the words of Chang (2008, p. 31), to share '… experience as expressed in lived and told stories.' I have drawn on my memories, reminiscing about those events that I remembered of my journey so that they can be

formed into story from the narrative. According to Chang (2008) autoethnography enables the researcher to apply an ethnographic description and interpretation of personal experience by using narrative to describe events.

Gaining understanding about how to write stories from the narrative of this research was a journey in itself. I initially explored the work of Ellis (2004), which assisted in clarifying for me the way that my story writing would go forward. Ellis (2004, p. xix), wrote that autoethnography is '… research, writing, story, and method that connect the autobiographical and personal to the cultural, social and political.' Ellis (2004) uses evocative writing in her autoethnographic studies. This is particularly evident in the book *The Ethnographic I* that was written in a novel format. Ellis (2004) described in the novel a story based on how she worked with students to encourage them to write their own story from the researcher's perspective and to put the researcher as subject into the writing. Ellis (2004) shared her story of writing about history and events and their impact on people throughout the text. In one scene Ellis is talking to her partner Art Bochner, a fellow academic and co-author, and states 'Autoethnography stories really make theory and history come alive', to which Bochner replied 'There's nothing more theoretical than a good story.' (Ellis, 2004. p. 23).

I have developed the stories that have evolved from the Timeline narratives by reflexively undertaking analysis and interpretation of them and related documents to detect the '… cultural undertones' of similarity revealed there (Chang 2008, p. 48). As I wrote, reviewed, interpreted and rewrote the description of my journey I sought to crystallize the multiple sources with the story to make meaning from my story. Throughout the process I remained conscious of the words of Goodall (2009, p. 42) who, when explaining about the nature of writers, wrote:

> … learn to find storylines by paying attention to their selves in relation to the details and patterns of everyday life and reading large the potential for connection. It is through the

> process of writing that we connect those details and patterns back to ourselves, and, through the magic of language, to something else.

Denzin (2014, p. 1) likens storytelling to 'pentimento' when he writes:

> Stories are like pictures that have been painted over, and, when paint is scraped off an old picture, something new becomes visible … Something new is always coming into sight, displacing what was previously certain and seen.

When I read about Denzin's idea of story-telling as pentimento I had a flash of realisation that this was what I had been experiencing during the writing of my own story. The writing has brought with it the wonder of what my memory and reminiscence has revealed, much of which I had not thought about for many years.

Reflexivity

The focus of the reflexive writing is essentially the theory and practice of autoethnography, which is '... reading significant patterns and signs in everyday experience and connecting those patterns to the self and to broader social and cultural concerns' (Chang 2008, p.139).

In support of the reflexivity in autoethnographic writing Adams, Holman Jones and Ellis (2015, p. 10) state that the essence of good story writing is '... telling personal and reflexive stories.' Ellis (in Adams, Holman Jones & Ellis 2015, p. 67) explains that '… it is difficult, if not impossible to separate doing autoethnography from writing autoethnography.' Among the common priorities and concerns is the way in which the autoethnographer uses and shows reflexivity (Adams, Holman Jones & Ellis 2015). The reflexivity of the research is also, according to Muncey (2010, p. 55), '… the awareness of being aware which allows us to represent and re-present the products of our imaginations in a variety of ways.' It is, according to Macbeth (2001, p. 35), '… a deconstructive exercise for locating the intersections of author, other, text, and the world, and for penetrating the representational exercise itself.'

Reflexive writing is an important part of my story writing that makes up a significant part of my data, enabling me as subject and writer to move in and through the various data interpreting and analysing. In so doing it has been important to keep the subject located both in the foreground and in the background in focus. I have written reflexively looking backwards and forwards in and through my journey and the other sources. This reflexivity is reflected in Muncey's (2005, p. 3) approach to her nursing story in explaining:

> … my story represents this messy iteration looking backward and forward, examining images and memories through a lens that has been influenced through my experience and reflection on the interaction of nursing and research.

Chang (2008, pp. 75-6) advises the autoethnographer that:

> … during your autoethnographic research, you will collect lots of information bits. Some of them may appear more useful to your study than others at the time of collection…. To avoid a total sense of randomness in your data collection, you may use inventory as a starting activity. …The inventory activity involves not only collecting but also evaluating and organising data. You collect memory bits when recalling and writing them down.

When writing the narrative of my memories about the journey I took I drew on bits of personal data, commencing essentially as a chronological autobiography. I wrote the memories as data from the timeline drawing on my own history and experience using what Chang (2008, p.126) describes as writing reflexively '… fragments of memories strung together to explain the culture.' These narratives are taken from the data and were written as story.

THE FINAL CHAPTER - REFLECTIONS

In preparation for writing the final chapter I analysed the thematic chapters by re-reading them in their entirety, exploring the chapters and identifying what I had learnt about nursing education from the stories that I had written as well as from the related literature. As I explored these chapters I developed a Timeline of Change in Nursing Education 1964 to 1994 – Comparison (see Appendix 13) This timeline makes a comparison of my experiences throughout my career set against the initiatives being undertaken by government and the profession. I have identified

events that occurred or resulted from the involvement of myself or with other members of the profession, and which are evident in the study thus allowing comparison of individual engagements. Five major outcomes were identified and discussed. Finally, a discussion of the implications of the study for policy, practice, education and research is suggested in order to encompass some areas of concern.

The questions answered in this study are:

- *How do my experiences of nursing education reflect what was occurring in Australian pre-registration nursing education from 1964 to 1994? What can be learnt from my experiences?*

The way in which the research was undertaken has achieved the two aims of the research. These are:

- identifying what new perspectives of nurse education my personal story reveals about nursing and nursing education in Australia during the period 1964 to 1994.
- gaining an understanding of how nursing education has been shaped over the period of my personal nursing education experience, taking into account the social and political and professional activities that have occurred during this time,

Chapters Three, Four and Five achieve the first goal of the research, which is:

- to explore, explain and describe the research participant's experience of nursing education in the period under study.

The second and third goals of the research are addressed in Chapter Six of the thesis and are:

- to explore and describe the outcomes of the research approach of autoethnography,
- to generate knowledge about nurse education in Australia in the period 1964 to 1994, through comparison and contrast of documented events and my personal experiences.

CHAPTER THREE - ENCULTURATION

> Much of the minutia of nursing care delivery was learnt at the bedside. Isolated elements which had been taught in classroom were perfected through a task oriented approach; the 'fluid nurse' or the 'obs nurse' spent days doing little else (Hills-Siegloff & Walker 1992, p. 230).

INTRODUCTION

My nursing journey commenced when I became an employee as well as a trainee nurse of a hospital training program in a small seventy-five bed hospital located in a suburb of Melbourne Victoria in August 1964. At the completion of this course I became eligible to be registered as a trained nurse. I commenced this program at a time in nursing history that was about a decade short of the commencement of the transfer of pre-registration nursing education in Australia to the higher education sector. In the 1960s all nursing education programs in the state of Victoria were offered as hospital-based programs and were based on a syllabus that was supervised by the Victorian Nursing Council at the behest of the Minister of Health. The Minister of Health, according to Russell (1990), prescribed the hours of learning of trainee nurses (the term used to identify nursing students at that time) and the educational requirements of the sister tutors who were the nurse educators teaching all the nursing programs. All states in Australia ran their own training programs that required varying lengths of study. In Victoria where I trained the program was of three years duration, as it was in South Australia where I became a nurse educator in the 1970s. Some other states including New South Wales, where I was first employed after I had completed my training, required nurse training of four years duration (Russell 1990).

In this, the first of the three data chapters of this thesis, I share my experience of being a trainee nurse while also being an employee of the hospital. I learnt my trade in the confines of one hospital in a seaside suburb of Melbourne. As a student, my learning was primarily undertaken in the clinical context over the three years. I have used my experience as an example of the story of a nursing student traversing nursing education during the 1960s. My story represents one view of

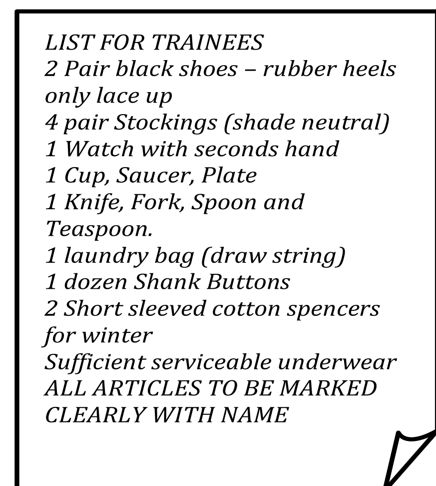
nursing education, however there were other activities and events relating to nursing education at this time being experienced by others. To ensure a more complete picture of the nursing education experience of the time I have included some documentation drawn from multiple sources to use as secondary data.

THE YOUNG GIRL'S JOURNEY BEGINS

SUNDAY, AUGUST 31ST, 1964

I sat very proudly beside my Dad as he drove me in the family car to the hospital at which I was going to start my nursing training. In line with the standards of the day I was wearing my best dress to mark this special day. The dress, while my best, had been a hand me down from my aunt - an aqua wool princess line that I had embellished with swan down around the cuffs. It was a sunny Sunday afternoon, the last day of August 1964. Dad was driving through the tree lined streets of suburban Melbourne. I loved Melbourne at this time of year. I could see the beginnings of spring, the blossoms on the trees just starting to open on this penultimate day of winter.

Figure 3.1: List for trainees



LIST FOR TRAINEES
2 Pair black shoes – rubber heels only lace up
4 pair Stockings (shade neutral)
1 Watch with seconds hand
1 Cup, Saucer, Plate
1 Knife, Fork, Spoon and Teaspoon.
1 laundry bag (draw string)
1 dozen Shank Buttons
2 Short sleeved cotton spencers for winter
Sufficient serviceable underwear
ALL ARTICLES TO BE MARKED CLEARLY WITH NAME

Source: Hills 1964-7 Scrapbook

I could hardly contain my excitement. After years of me talking about becoming a nurse it was happening. I was on the journey to my new career and life. Dad was as excited as I was, the two of us chatting as we drove along about what could be ahead when I was a trainee nurse. Unfortunately, Mum could not be with me on this special day. She was on duty in a hospital in another part of the city where she was a student midwife. Mum had been a nurse for twenty years and had recently commenced midwifery training, following the family's move from the country to the city in the previous year. Dad told me that he thought that I would one day be a double certificate nurse and maybe a triple certificate nurse, meaning that I would

qualify as nurse, midwife and child health nurse. In both of our opinions these qualifications would prepare me for a fantastic career and I would be able to work anywhere in the world. My excitement was mixed with some anxiety. I was leaving home for the first time and it was expected by my family that I would be successful in my endeavour. I was always second guessing myself and wondered, even then, what would happen if I wasn't smart enough to pass all the examinations that were ahead of me. It had been obvious that previous night, when my sister and I had been together in our bedroom chatting while I was packing, that the family had high expectations of my success.

While I packed all my worldly goods and the items on a list sent from the hospital (see Figure 3.1) into a small suitcase, my sister and I had been discussing what nursing training would be like. I had saved some of my small salary as a clerk so that I could buy what was required. I recall expressing surprise that I needed to buy cutlery and to have it engraved with my name, and crockery, because I thought that the hospital would supply this. My father, sister and the older of my two younger brothers and I were all crowded into my sister's and my bedroom. I remember that Dad was giving advice about how I should behave when I was away from home. Mum, who had been busy putting my four-year-old brother to bed, also came to join us and added her advice. I remember that it was a happy time of shared banter and there was a real feeling of anticipation in the air. The whole family appeared to be excited by the prospect of me becoming a nurse. That night before I went to bed my parents also told me how proud they were of me and gave me a new battery-operated transistor radio as a gift to take with me to the hospital. I had never owned my own radio, so it was a very precious gift. It was red plastic and very fashionable.

TO BECOME NURSE HILLS

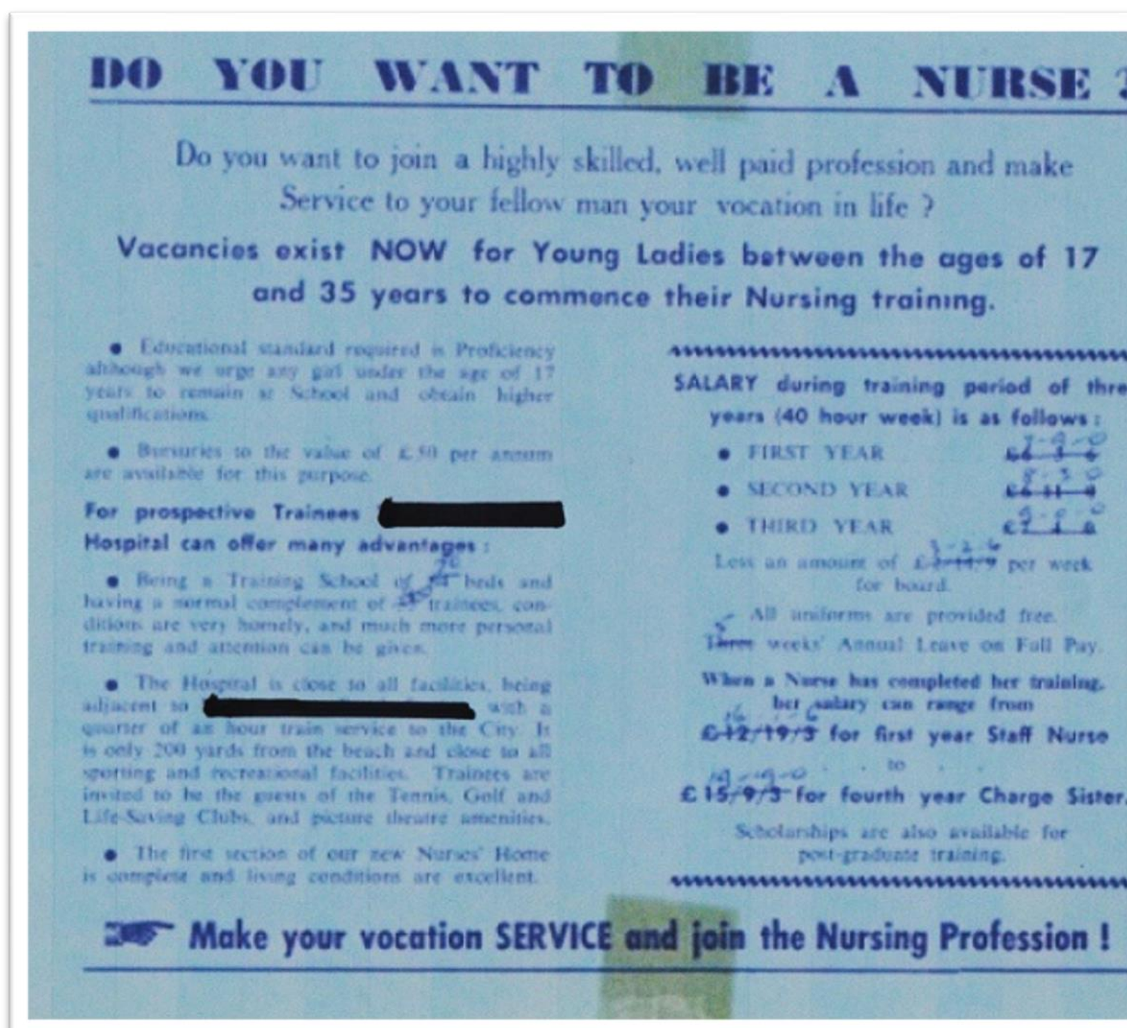
I was fifteen years old and in third form (year nine) in high school when Mum told me that if I was going to study to be a nurse I would need to apply to some hospitals in Melbourne. It was at this

time that she told me that she and Dad had decided that we were going to move from country Victoria to Melbourne. This was a disappointment to me because I wanted to train in a country hospital and was not confident about training in a large metropolitan hospital. It had never occurred to me that I would need to think about a city hospital because we had never lived in a major city while I was growing up. Mum also told me then that she was applying to do her midwifery training in Melbourne and was hoping to commence in late 1963, the same year in which we expected that I would also commence my nursing training. She and Dad thought that the whole family should be together in Melbourne. This would mean that Mum could do the midwifery training that she had wanted to do for some years, and it would also enable my sister and I to study and work near home. Dad applied for, and secured, a transfer with the company that he worked for and we headed to Melbourne. The idea that I wanted to do my training in a country hospital went out the window. Mum then showed me some newspaper advertisements about hospital training programs and told me to write to the hospitals to get information about their programs.

All nursing education programs of that period in Australia were offered as an apprenticeship and like many vocational education programs they were located '… outside the education sector' (Russell 1990, p. 53). At that time trainee nurses were an essential part of the nursing workforce of most hospitals in Victoria. According to Russell (1990), who wrote extensively about nursing education in Australia, students made up more than a third of the total population of nurses, both student and registered, in hospitals in the 1960s. Most general and district hospitals had some form of nurse training programs and in 1964, the year in which I commenced my training, a total of 106 Victorian hospitals ran such programs (Russell 1990). At the time of my graduation in 1967, 8748 registered nurses and 4604 student nurses were employed by hospitals and health agencies in Victoria (Russell 1990). I sent several letters of enquiry about nursing programs to hospital nurse

training schools in Melbourne in response to the newspaper advertisements that Mum had pointed out to me. I received several responses from various hospitals. Some required completion of Matriculation (year twelve), others accepted completion of Leaving Certificate (year eleven) and others including District General Hospital (DGH) would accept either completion of Proficiency Certificate (year nine) and Intermediate (year ten). The information about the program offered at DGH attracted me immediately because this hospital would take me when I was just over seventeen years of age and as long as I had passed the State Proficiency Examination (Merit Certificate - year nine). This examination was held at the end of the third year of high school (year nine) in Victoria. After the hospital administration had accepted my application I would be required, once I had evidence of passing this examination, to attend an interview and to pass an aptitude test and a medical examination at the hospital. If these were successful, I could commence my training in the next trainee intake after I had reached the age of at least seventeen years and three months. Mum and Dad agreed with me that this looked like the ideal training school for me, especially as it was not a large hospital and would take me when I was seventeen years old. I pored over the information that I had received from the DGH because it was so exciting to know that my future was so clear. A brochure, shown at Figure 3.2, had been included with the letter from the DGH.

Figure 3.2: Do you want to be a nurse?



Source: Hills 1964-7 Scrapbook. I received this brochure (I removed identification detail) from the Matron in response to my question about nursing training at her hospital (28th October 1963). Hand written salary information on brochure 1st year salary: £7.9.0; 2nd year salary £ 8.3.00 and 3rd year salary £ 9.0.0 – Board £ 3.2.6.

Russell (1990, p. 59), when describing the entry requirements for nursing students in Victoria during the 1960s, elaborated:

> In Victoria, the prescribed age for entry to general nurse training was set at 17. The majority of students entering general nursing courses in Victoria between 1966 and 1969 had completed fifth form (59.6 per cent). The next largest group of entrants (26.45 per cent) had only completed fourth form. The smallest number of entrants (8.95 per cent) had completed sixth form.

I showed the DGH brochure to my school friends – two of them also wanted to train as nurses. Unlike me, they had both decided that they wanted to train in the large Royal Melbourne Hospital and that would mean that they needed to pass matriculation – twelve years of school. The brochure stated that young women between the ages of seventeen and thirty-five could become nurses in '… a highly skilled well-paid profession and make Service to your fellow man (sic) your vocation in life'. The idea struck a chord and this information, coupled with not being required to have matriculated, reinforced my decision to apply to DGH.

For me matriculation seemed unattainable and seemed to be more appropriate for students interested in more professional careers such as law and medicine. I had no experience of family members who had completed matriculation at that time. I didn't want to waste my time with extra school education when I could be earning a living and doing my training at the same time.

I needed references from three reliable people who could attest to my good character to support my application. I sought references from the reverend mother who was the principal of the convent where I had completed high school, the local parish priest, and our neighbour from my younger days. Because I did not at that time have a personal copy I subsequently made photocopies of these original documents from the hospital archives on my visit there in 2010 (transcriptions shown at Figures 3.3, 3.4, 3.5).

Figure 3.3: Parish priest reference 26/11/63

Dear Matron

I can strongly recommend Miss Leslie Mary Hills, who has applied to you for a position to train as a General Nurse in your Hospital.

She is a particularly good and practical girl & I am sure she will give thorough satisfaction. Her parents are excellent people.
I am
Yours Sincerely etc.

Figure 3.4: Female family friend reference 1/11/63

Dear Matron
Having known Leslie Hills for a period of over seven years, I have no hesitation in providing her with the highest personal reference. I have always found her honest, capable and industrious.

Yours Sincerely etc.

Figure 3.5: Teacher's reference 1963

To whom it may concern

During the two years that she spent at our school, Lesley Hills has given satisfaction to her teachers in regards both to her conduct and her application to study. She is a gentle courteous girl, respectful of her teachers and always willing to help others. She has a keen sense of duty. These good qualities, I feel sure, will be of great assistance to the nursing

Yours Sincerely etc.

Source: transcribed from letters held in the hospital archive

It is interesting to see the words that were used to describe my character such as honest, capable, industrious, practical, respectful, courteous and gentle, which characterised for them their view of qualities necessary to be a good nurse and therefore my capacity to be a nurse.

None of the referees wrote about my academic ability however they were vociferous in their opinion of my good character and ability to be a good, caring girl. Not only did the references have an opinion about my character, the parish priest also mentioned in his reference that my parents were '*excellent people*'.

The nursing course that I was commencing was run by the DGH and was similar to all other hospital-based nursing programs offered at that time in Victoria. The training school was part of the hospital. The classrooms of the training school were in the hospital that ran the nursing training course. Registered nurses were employed to teach and were known as sister tutors. Not all sister tutors were qualified teachers. Because the DGH was a small hospital, which had only three very small intakes of students each year, there were only two sister tutors employed, one of who was called the Principal Sister Tutor. She was in charge of the school and reported directly to the Matron of the hospital. In other hospitals the programs were larger and there were more tutors employed, and in some the senior tutor was known as the Principal Nurse Educator. According to Russell (1990, p. 55), the Principal Nurse Educator was:

> … a member of the nursing staff ran the school of nursing, which was a unit of the hospital under the control of the Matron and organised the educational program for the trainee nurses. The Matron of the hospital was the most senior nurse and was responsible for the nursing staff, a major component of whom were trainee nurses, and for the quality of patient care throughout the hospital.

I completed my final paperwork application to become a probationer at the DGH and sent it to the hospital on 21st November 1963. I was sixteen years and six months old when I left high school on 12th December 1963, having completed my intermediate certificate at the completion of year ten (otherwise known in Victoria as form four). I had taken the advice on the brochure to stay at school an extra year because I would not be seventeen until May 1964. In the meantime, I took up a job as an interoffice clerk in the following January while I waited to start my training. I was notified that I would commence my training in the next available course beginning on 31st August,

after I had met the age requirements on 27th August 1964. I received a letter from the Matron advising me to report to the hospital on the 30th August in the afternoon '… in time to settle in and have tea' (Hills 1964-7 Scrapbook).

I took up a position as an interoffice clerk in a Victorian Government department while I waited to be old enough to commence my training. It turned out to be a good way to prepare for future work demands, becoming used to following the rules of an employer. As part of my job I spent mornings in the mail room with twenty other women sorting what appeared to be mountains of mail. The department was responsible for the registration of taxis, trucks and commercial vehicles for all of Victoria, including the licensing of the drivers of these vehicles. Large sacks of mail arrived at the department early every morning. Among the letters were cheques that needed to be responded to with a receipt. The sorted letters and cheques were sent to the payments department and then the letters were subsequently distributed to the various offices in the department. After we had completed the sorting each morning it was my job as the interoffice clerk to place the various letters and cheques into the pigeon holes in my section of the department, and then to distribute the letters to the various office in-boxes and to collect documents from their out-boxes. I would then return to my section and report and eventually go on my second trip around the offices in the afternoon to put even more letters into the office in-boxes.

The work that I did as an interoffice clerk was very repetitive and at times I found it very boring. Little did I know then that I was building resilience which would help me to sustain the repetitive nature of my future nursing career.

The desire to be a nurse was on my mind for those few months while I was working in that job. Although I enjoyed the friendship of the women I was working with, I knew that it was for a

limited time. I could hardly wait to be old enough to go to nursing school. The thought kept me buoyed when I went to work each day. I could see that there was light at the end of a very boring tunnel. I could also see that the women I was working with were quite disadvantaged in the world of this department. I realised very early in my employment that the young men with whom I worked and who had left school at the same time as I had more advantages for the future than the women, who didn't seem to have much future in the department.

Many of the other women who I worked with told me that they were glad that I was going to be a nurse. They explained that they were sorry that they had not found another job that would give them more satisfaction. Some had told me that they had been held back from more interesting jobs because they had left school too early. They also realised that they would never be in line for any management roles even if they had stayed longer at school because no matter how long they had worked in the department they couldn't get promotion. The men seemed always to get in ahead of them. I realised that I had an advantage over these women who had found themselves trapped in their role, doing the same job in the same department for years, even when they were bored with their work. Young men were employed, unlike young women, into positions that could lead to management and leadership positions. The women and girls in this department could only work as a clerk, an interoffice clerk or as a secretary. The highest role that they could aspire to in this department was as a team leader in the mail room, even after twenty years of employment.

On my last day in the department the female colleagues who I had been working with gave me a farewell afternoon tea at which I received many gifts. Among the gifts was a small book called the Baillier's Nurses' Dictionary edited by Cape (1963). This little book is still sitting on a shelf in my bookcase among many of my other precious mementos of my nursing career. It was given to me by one of my co-workers who had herself wanted to be a nurse but had not fulfilled her ambition. She told me that she was happy to see me commence the career that she had hoped for and, now

that she was close to retirement, hoped that I would have a more successful time than she had. I recalled her wish for me as I travelled that first day on my journey toward my new career.

In those days, as the child of working-class parents, there were limited opportunities for me to undertake post high school education. University education particularly was nowhere on my radar. While it was not spoken of outright, I knew that I was from the wrong (disadvantaged) class even if I aspired to go to university. No one in my family at that time had been to university and even if I had matriculated with the appropriate grades, which would have been necessary, my family could not have afforded to send me to university. I remember that just before I decided on my future I was talking to one of my school friends whose mother was the local general practitioner. My friend was clear that she was going to be a doctor like her mother. I knew that their family had expectations as well as the financial capacity for their children to go to university. I also knew that I did not belong in that circle, so her decision did not cause me any concern because I was happy to be going to nursing school.

Other than nursing, the only other job options that I knew about for most girls, besides my school friend, was as a shop assistant, a teacher (which meant going to teachers' college), joining a religious order and becoming a nun, hairdressing, going to commercial college to become a stenographer or secretary, or becoming an airhostess. Although I had since travelling on an aeroplane to visit Dad's family in Tasmania at the age of twelve formed a very romantic idea of becoming a hostess this soon changed when I realised that I would not be accepted. I was not tall enough to be an airhostess. My parents did not approve of this job because in their opinion these girls' morals could be at risk! My other option would have been to remain as an interoffice clerk in the job that I had been doing since leaving school, but in which I was not interested in continuing because I had come to believe that it was obviously a dead-end occupation. My knowledge of

female occupations was similar to what Lumby (2005), another Australian nurse who had studied nursing in the 1960s, described.

> *I wonder now whether becoming a nurse was really a decision that I had made or was I, as was usual for me in those late teen years, doing what was expected of me by my family, particularly my father? My mother told me later in life about my father encouraging me to become a nurse when I was quite young. I remember that she thought that he had brainwashed me into nursing from an early age. All his conversations about my future as I was growing up included the assumption that I would become a nurse. Sadly, although he proudly took me to the hospital on that first day, he never lived long enough to see me graduate.*

Mum supported Dad's idea that nursing would be an ideal career for me and both of them also thought that my sister should also make it her career. It was never thought of as a career for either of my brothers. As was my habit as a young girl I always wanted to please my parents, and this instance was no exception and resulted in me, like them, seeing myself as a nurse from a very young age. My sister, who is one year younger, was more difficult to convince and she didn't commence her nurse training until after my father's death. As well as thinking that it was an excellent career for a young girl, my parents were equally happy because, even though I would be leaving home, I would be supervised in a similar manner - just as if I had remained at home. Also, I had the potential for a secure future and would also be receiving a wage while I was training, which meant that Mum and Dad would not need to support me financially.

I didn't really have much idea about the role of the nurse other than what I had seen in the movies and had read in books, even though my mother was a trained nurse who had several nursing friends. I had only ever had one experience of being in hospital as a child and that was when I had

gone to work with Mum one night when she was working on night duty because I had tonsillitis and needed to be observed. The next day I returned home with her when she went off duty. My memory of that night is of Mum walking quietly around the ward dressed in her white uniform dress and veil. She looked so mysterious in the light of the ward in the night and I remember feeling very proud that she was my Mum. We lived in a small rural town and the local hospital had very few beds. Most patients were those who had returned to the town after having surgery in the nearby regional hospital, or they had a general medical condition, or they were women having babies. Mum was unlike all my friends' mothers because she worked away from the home. However, because she was a nurse, that seemed to be acceptable to the people in the small rural community.

> *By deciding on nursing, I was not only choosing a career but was conforming to the expectations of my family. I was also aware at that time that there were very few options for girls to have a career. It was a time when married women rarely worked. They were expected to stay at home and look after the family. The few mothers who worked in our town were shop owners, nurses and teachers. Most other mothers stayed at home and did not work. In accordance with this view I knew that if I was to marry many people would think that I should give up work. Conversely, I knew from the example of my mother that if I did want to work later in life, nursing was one occupation where it might possible.*

Many of the trained nurses known as sisters, including the matron, were single and lived in the nurses' home attached to the hospital. These nurses often depended on one another for their social life. The matron was one of my mother's friends and I knew that she was in charge of the hospital. She was also the godmother of my youngest brother. Mum was the night sister and our neighbor worked with her on night duty as a nurses' aide. Because Mum was not a midwife the

matron, who was a midwife, was on call for births. The two local general practitioners were also the hospital doctors and generally delivered the babies. I grew up knowing the sisters and the matron of our local hospital, however this knowledge did not give me any advantage when I commenced my training.

Over the years I have sometimes wondered if my enthusiasm for studying nursing would have changed if I had read what was written in the letters to the editor section of the *Australian Womens' Weekly* (8 January 1964, p. 3) which was published seven months prior to my commencing training. It was headed *Advice on nursing as a career for girls*. One of the correspondents quoted in the article pointed out the heavy workload that could be visited on a first-year student, writing:

> If you are an intelligent and fairly placid person who does not object to working hard at top pace you'll find nursing a most rewarding job. But if you are extremely nervy, moody, tire easily, and have a strong tendency to be caught up in other people's lives and emotions, and especially if you don't like being bossed, then you won't get through the first year.
>
> The first year is the worst, once over that there is every chance that you'll complete the course and love it.

Another correspondent explained that she had not continued with her training but could certainly see some value for the person who had done a nursing course, even if they didn't graduate, because it would prepare a girl well for marriage. Her views were:

> I spent eight months in the profession, but found it a bit too much, so here is my advice. Give nursing a chance as your career.
>
> It is a wonderful profession. If you marry at the end of training, nursing provides a perfect foundation for bringing up a family. If you remain unmarried you can look forward to a full and rewarding life.
>
> Finally, if you do choose this career, then find it unsuitable, don't be ashamed to give it up.

Probably because I didn't have access to magazines in those days I did not have access to this information so had no indication of the opinions written there. My knowledge of nursing came from the limited stories I had heard from my mother and the story books about nurses written for young girls as well as some movies.

Without being privy to this information when I left home on that afternoon in August 1964 to travel to the nurses' home, which was to be my home for the next three years, I felt very grown up and excited about what was ahead. Russell (1990), when writing about nurse education in Australia prior to 1990, made a comment about the tradition of requiring students in hospital-based nursing education programs to 'live-in' until the 1960s. Russell's (1990, p. 63) explanation made a connection to the original expectations of Florence Nightingale which were to ensure appropriate behaviour of nursing trainees, stating:

> The origin of the restrictions and regulations can clearly be traced to the principles enunciated by Florence Nightingale. Living-in was seen as an essential component of nurse training, so that the correct morals, manner and behaviour that Florence Nightingale saw as such an important part of nurse training could be inculcated.

RULES TO LIVE BY

WHERE TO LIVE

After an hour of travelling through the suburbs of Melbourne we reached our destination on that first day. Dad pulled the car up in the side street beside the nurses' home where I was required to live. I got out of the car and stood on the footpath to wait for him to get my suitcase, which held all I owned, out of the car boot. I glanced to my left and there, at the end of the road, I could just see the sea. I had never lived this close to the sea before. I loved what I saw - it added to my excitement. I felt like I had on the rare occasions on which my family went on holiday - very excited. I looked from there to the nurses' home and realised that this was where I was going to live for the next three years. I felt very grown up.

Dad carried my suitcase as we walked up to the front door of the hospital. He asked the receptionist if we could see the Deputy Matron (as I continue this next section she will be referred to as 'Sister'). When Sister arrived, I noticed that she was dressed in a white uniform dress over which she wore a red nurses' cape that came over her dress to her waist. She was also wearing a very large nurses' veil on her head. I had first met her when I had come for my interview and aptitude test at the hospital three months previously. After welcoming Dad and myself she told us that she would take us to the nurses' home next door. We followed her the short distance and she let us in the front door into a small sitting room. Dad and Sister had a short conversation and then she explained to Dad that he could not come into the nurses' home with me. When she told me to say goodbye to my father she called me '*Nurse Hills*'. That was the first time I had been called '*Nurse*'. It gave me a tingly feeling. Dad looked so proud and kissed me goodbye, reminding me to ring Mum later in the evening. He handed me the suitcase and he walked back down the path to the car.

I stood for a short time watching Dad walk out of the gate to the car. I was at the same time excited and anxious. I was excited because I was standing in a nurses' home and I was going to become a nurse. I had been looking forward to becoming a nurse for most of my young life. I was also anxious about whether I could do what was required to become a 'sister' because I was not sure if I would be smart enough and I really wanted to make my parents proud when I finished the course.

The act of writing and rewriting about that first morning of my training transported me back in time. I felt the confusion and apprehension, as well as the excitement, of commencing what I did not know then was to be a nursing career spanning over fifty years. I remember watching Dad that day and that memory reminded me of the last day I saw him sixteen months later as he

walked down that path after he had delivered me back to the nurse's home after my rostered days off. On that day, he reminded me that he wanted me to be home on the following Tuesday because he had a childhood friend coming over from Tasmania for a visit. But I didn't see Dad again. He died in a car accident on the following Friday on 10th December 1965. He was forty-two years old. I did meet his friend however. He was at Dad's funeral in the following week. I was always sorry that Dad never saw me complete my nurse training and commence life as a registered nurse. My mother, on the other hand, had been watching and supporting me throughout my nursing journey and at the time of writing this paper she is ninety-six years old and continues to have a very agile brain.

After I had watched Dad walk down the path I followed Sister into the nurses' home. I looked around the building where I was going to live. There was a large open lounge room just inside the front entrance. I could see girls in various stages of dress - some in dressing gowns, others in uniform and one girl standing in the doorway talking to the others. She was dressed in a very smart outfit and I thought that she looked like she was ready to go out. She disappeared quickly when the front door bell rang.

I could hear music coming from a gramophone in the corner of the large lounge-room, opposite the television. Sister went into the room and asked the girls there to turn down the music. She reminded them in a firm tone of voice to remember that the nurses on night duty might be trying to sleep. The girls sitting in the room looked startled and stood up quickly, and then one of them walked over to the gramophone and turned down the music. Sister introduced me to the other trainees in the lounge-room and then she directed me to walk along with her. Carrying my suitcase, I followed her. As we walked along I looked around in wonder and realised that this

building was buzzing with girls going about their business. I realised with a thrill that I was now one of them and a part of this place.

As we walked along I saw another girl, who was wearing a dressing gown, coming out of what looked like a very small kitchen. I later learnt that it was called the pantry. The girl was carrying a plate of toast and a cup of tea. In the years that followed I used the pantry a lot to make many pieces of toast when I didn't want to go to the dining room for a meal. Sister acknowledged the young girl and asked her if she had left the pantry clean and tidy. The girl said, '*Yes Sister'*, and we moved on. Then I heard a telephone ringing somewhere nearby. One of the other girls who had been sitting in the lounge ran past us - she was on her way to answer the telephone. '*Don't run Nurse!*' called Sister.

> *This was a mantra that I heard a great deal over the next three years. We were told constantly that the only time to run was when there was an emergency, cardiac arrest, haemorrhage or fire! I noticed later that there were two telephone booths holding pay telephones located at the foot of the stairs.*

Sister then led me up the stairs and when we got to the next floor I could hear the girl who had answered the telephone call out to someone else that the call was for her. Sister turned to me and informed me even more firmly that I should remember not to call out in the corridors of the nurses' home at any time especially, she reiterated, because other trainees who were on night duty could be trying to sleep. There was no special sleeping area in the nurses' home for the trainees who were on night duty. She went on to explain that if I wanted my family to contact me by telephone that I would need to let them know the telephone numbers and when I was available, and that they could call me on one of the two telephones in the nurses' home only when I was off duty.

By the time that Sister had finished talking about the telephone I was starting to feel worried. She seemed to have so many rules to tell me and she appeared to be more concerned about them rather than encouraging the trainees to enjoy their off-duty time, in what was at that time their home. Given my penchant for not doing the wrong thing I thought that I was going to have to be very careful, even though I was used to conforming to rules at home. I dreaded the thought of breaking rules and being chastised by Matron or the Deputy Matron and continually thought of the consequences if Mum heard that I had got into trouble. She would be very disappointed in me. While rules were a part of my life at home I had learnt how to obey them and to avoid getting into trouble. My concern about my mother's good opinion of me was always at the forefront of my mind. I also knew that if I wanted to finish my training rule-keeping would be important.

Sister opened a door two rooms up from the bathroom, which I had noticed as we walked along the upstairs corridor, and she handed me the key and instructed me to unlock the door. She then walked ahead of me into the not very large room and told me that it was to be my bedroom for first year. I saw that there was a small single bed with a book-case bed head, a built-in wardrobe along one wall with a dressing table included which could also be used as a study desk, and a foot stool to sit on and to put shoes into. There were heavy olive-green curtains with a geometric design on them at the window and green linoleum on the floor. I thought that the bedroom was fantastic because it was to be my room alone.

I was used to sharing a not very large bedroom at home with my sister. This was the first time in my life that I had a bedroom all to myself!

As I entered the room I was also happy to see the uniforms which were laid out on the bed. That was what I had really been looking forward to. It was the

one important symbol of my becoming a nurse. I had been measured for the uniforms three months previously. On the bed there were five starched blue uniform dresses, five starched white aprons, a red cape and three starched 'first-year' white caps.

Sister looked at me and, indicating the uniforms, asked me if I had brought shank buttons with me. I found them in my suitcase and handed them to her. She explained how they would need to be put into the small holes located down the front of my uniforms on the side opposite the button holes. She showed me how to attach the apron to the top buttons located just below my shoulders at the front of the uniform and the way to put a button in the band of the apron to bring the back together. She then went on to show me how to fold my first-year nurse's cap and to explain that I would need to deliver my dirty laundry (uniform items only) in my laundry bag to the linen collection room downstairs every Tuesday. Explaining that they would be washed, starched and ironed and returned to the nurses' home on the following day. She warned me to remove the shank buttons before any uniforms were sent to the laundry because if they were left in a uniform they would get caught in the machine and the uniform would be torn. She continued to tell me that next morning I needed to be dressed in my uniform and to report after breakfast to Matron's office by 8am, after which the Principal Tutor Sister would collect me and my other colleagues to take us to the training school.

HOW TO DRESS AND BEHAVE

Sister introduced me to many rules on that first afternoon. At that time, they became indelibly imprinted on my mind because I wanted to be sure to follow the orders and behave in the manner expected of me. She told me about bedtime - that I needed to be in bed by 11.45 pm with lights out every night if I was not on night duty. She also told me that the night supervisor would be coming around to check our rooms to see that we were in bed on time every night. I could have

one late pass each week until 12 midnight, and this was expected to be used to go to the pictures (we were a one-hour train ride from the city). If I arrived back after 11.45 pm I would need to go to the hospital main entrance to be let in by the night supervisor.

I could have one ball pass each year until 2 am, and of course was expected to go to the hospital ball. I was also told not to think that this would always be my room as I would need to move out of it and take all my possessions with me when going on holidays at the end of first and second year. She went on to tell me that trainees on night duty must be in bed by 9am and were not to leave their room until 3 pm unless they had to attend a lecture during the day.

> *Noise seemed to be a continuing issue for Deputy Matron. No yelling was allowed in the corridors. Phone calls could be made in the phone booths on the ground floor, but voices had to be kept low and trainees were not to yell out to one another. We were always to go to the students' rooms if we needed to talk to them, however we were not to be there after lights out.*

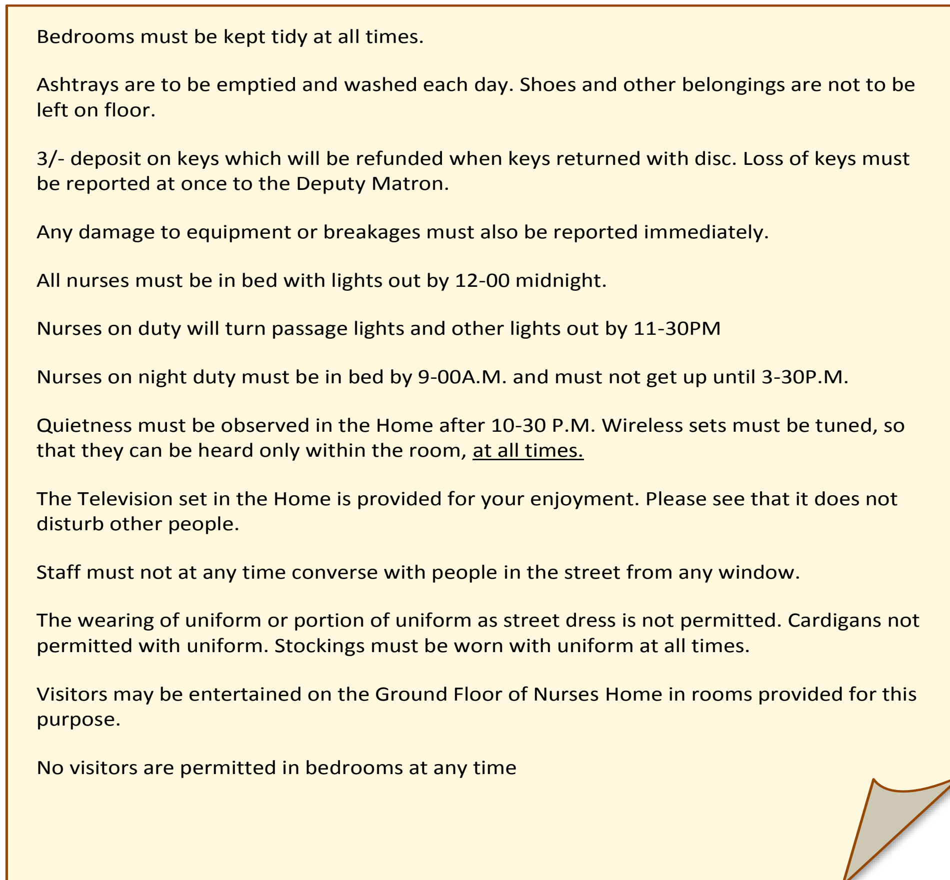
My one remembered misdemeanour involved me yelling out to my friends. It occurred when I was in third year and it did cause me to be ordered to Matron's office by Matron herself. I was leaning out of the window of my bedroom talking excitedly to my friends who were about to head for the beach when I looked down straight into the face of a not very happy Matron. *Nurse Hills see me in my office in the morning*, she called up to me as I stood at the window.

Another important rule never to be forgotten was that all must, when having meals in the hospital dining room, be in full uniform when on duty and must dress in neat casual attire when off duty. Also, when Matron entered the dining room, even when we were eating, everybody had to stand until she was seated.

Before she left my room, Sister reminded me to always wear an apron over my uniform when I was on ward duty and in class, and to remember to remove it when I went to the dining room for meals and when I was seeing Matron in her office. As she left the room she indicated a brochure, an excerpt of which is shown at Figure 3.6, labelled '*For Your Information*' and which was pinned to the back of the door. This brochure was commonly referred to as '*Nurses Home Rules*', which included rules about how I was to keep a tidy room.

> *I was relieved when she left me alone in my room with my head spinning from all this new information. I wanted time to think and to look around. Sister had told me that the other trainees who were to be in my group had not yet arrived. I was sorry about this because I didn't feel confident enough to go back downstairs to the nurses' lounge and I wanted to share the feeling of excitement of the mysteries ahead with someone else who might understand. It was also too early to ring home to talk to my sister and Mum because they were both not going to be home until late. So, I read the rules.*

Figure 3.6: Excerpt of contents of brochure 'For your Information'



Bedrooms must be kept tidy at all times.

Ashtrays are to be emptied and washed each day. Shoes and other belongings are not to be left on floor.

3/- deposit on keys which will be refunded when keys returned with disc. Loss of keys must be reported at once to the Deputy Matron.

Any damage to equipment or breakages must also be reported immediately.

All nurses must be in bed with lights out by 12-00 midnight.

Nurses on duty will turn passage lights and other lights out by 11-30PM

Nurses on night duty must be in bed by 9-00A.M. and must not get up until 3-30P.M.

Quietness must be observed in the Home after 10-30 P.M. Wireless sets must be tuned, so that they can be heard only within the room, at all times.

The Television set in the Home is provided for your enjoyment. Please see that it does not disturb other people.

Staff must not at any time converse with people in the street from any window.

The wearing of uniform or portion of uniform as street dress is not permitted. Cardigans not permitted with uniform. Stockings must be worn with uniform at all times.

Visitors may be entertained on the Ground Floor of Nurses Home in rooms provided for this purpose.

No visitors are permitted in bedrooms at any time

Source: Hills 1964-7 Scrapbook

Another important rule was that I could not stay out of the nurses' home for even one night without having gained a leave pass from Matron, even when I had days off and when I was going home to my parents. This meant that I needed to go to Matron's office on the day before with the leave request form and she would check that my parents knew where I was going if I wasn't going home. This rule also applied to the international trainees whose home was in Hong Kong even though they did not have the ability to contact their parents quickly to get permission to leave the home overnight, as well as to trainees who were of age. Among these rules about how and where the trainees spent their after-hours' time was a ban on alcohol in the nurses' home. This included on special occasions such as the trainees' Christmas party. We were warned that if we were found to have alcohol in our bedrooms or the nurses' home we would be instantly dismissed.

These many rules seemed mostly to have a focus on how to live a good and chaste life as a member of the student population seemed at times to paralyse my capacity to think for myself.

Rules of living among others were not new to me. When I was growing up Mum spent a great deal of time with my siblings and myself teaching us about rules of behaviour that she and Dad expected of us. Among them was the requirement to make sure that we were always considerate of others and not to think only of ourselves. We must always be polite and obey the rules wherever we were, including being neat and tidy in our dress.

Before I commenced nursing my mother talked to me at length about needing to study hard, to do what I was told and to make sure that I did not get into trouble in the hospital. The underlying message was to always be good and remain chaste. Her attitude seemed to be driven as much by the attitude of the day about the risk of young girls getting into trouble and becoming pregnant. Not only was it shameful - it was a sin for a young Catholic girl and she reminded me that if I broke rules in the hospital it would also mean the end of my training. With that message firmly stuck in my mind I started my journey knowing that I needed to be good and not to cause my parents concern – knowledge learnt when I was young.

Later that first evening Sister came back to my room and introduced me to Annette, one of the other trainees who had just arrived and was also starting in the new group. Annette's room was in the same corridor as mine. Annette and I were both quite young at seventeen and we had little previous life experience, both of us having recently left school and neither of us having lived away from home before. We had both left home for the first time and were about to embark on a life of

many rules, including when we were to get up and go to bed, and having to ask permission to be out after midnight and to go home on days off. I found that these and other rules sustained and guided me, especially for the first year, however they came to feel constraining as I grew older.

> *During my life as a student I became aware of other expectations being placed on students that at times limited our freedom. I learnt other rules. No matter the age or experience of the trainee nurse we were all required to live in the nurses' home and maintain the rules and regulations set down by the hospital. There was one student who was married, and she not only had children, she was also a grandmother at 42 years of age. She was required to live in the nurses' home and could only have leave passes to live at home on her days off and, like the rest of us, only if she did not have lectures on that day.*

The other two of the four students in the group, Jenny and Barbara, were twenty and thirty years old respectively and had both previously been nurses' aides. Even given their age and experience they too were required to conform to the rules. These other three trainees in my group became my closest friends over the next three years. We lived in the same nurses' home, did classes and studied together, did similar shifts and laughed over the funny events and cried over the sad events we were to encounter. We suffered the anguish which, it appeared, only we could suffer while trying to make sense of our world.

CONFORMING TO THE RULES

After dinner on the first evening I ironed my uniform and unfolded and re-ironed the new first-year student nurses cap that sister had folded for me.

> *I was excited about wearing this symbol of being a nurse and wanted it to look perfect. I looked in the mirror and tried to put the white box-like form on my head. It was difficult and even though I was proud of what I saw I knew that*

it did not look quite right balanced precariously on my head. At that moment I thought that it looked ugly. I really hoped that I could make it fit and look better the next day.

Before I went to bed that night, I wrote my first entry (Figure 3.7) into the new scrap book that I had brought with me to record some of the events of my training days.

Figure 3.7: The entry I made in my scrapbook on the first evening.

SUNDAY AUGUST 31ST, 1964 – AGE 17 YEARS AND 3 MONTHS.

TODAY WAS THE FIRST DAY AS A NURSE. ALTHOUGH I DID NOT START ANY DUTIES I WAS ABLE TO BECOME ACCUSTOMED TO THE NURSES HOME. THE ROOM IS VERY SPACIOUS CONTAINING A BED, LAMP, CHAIR AND STOOL AND COVERING ONE WALL IS A COMBINATION WARDROBE AND DRESSING TABLE. CONTAINING ALL THESE ARTICLES IT IS STILL VERY ROOMY. IT FEELS VERY FUNNY AT THE MOMENT. EVERYTHING IS SO QUIET. THE TIME IS 8.40PM. I HAVE HAD MY SHOWER AND IRONED MY UNIFORM. AND FOR SOME PECULIAR REASON I FEEL RATHER TIRED, SO I THINK I WILL GO TO BED EARLY. I HAVE MET THREE OF MY FELLOW STUDENTS BUT TWO HAVE NOT ARRIVED. WE HAVE NOT HEARD WHETHER THEY ARE STILL COMING OR NOT. I HAD BETTER CLOSE AND DO MY NAILS AND GO TO BED.

Source: Hills 1964-7 Scrapbook

On the first morning, I arose early and went to the bathroom in my dressing gown. I met up with the other three nursing friends from my group there and we arranged to meet for breakfast before we reported to Matron. I asked Jill, one of the older trainees who was a member of the group ahead of me, if she knew how to make the cap sit securely on my head so that it would not fall off. She asked me if I had some *Kleenex* tissues. When I told her that I did she said she would come to my room and help me. When she came to my room she taught me the mysteries of attaching the cap to my hair. She folded a *Kleenex* tissue in four and directed me to pin that to my hair on the top of my head with two bobby pins. She then produced a long straight pin with a white head on it and instructed me to put the cap on my head over the tissue and push the pin

through the cap into the tissue, bringing the point back out of the cap. I tried the first time and stuck the pin into my scalp: I drew blood for the first time in my nursing career. I tried again, struggling to get the hat pin through the heavy starched fabric.

After all the frustration, the cap was at last firmly placed on the top of my head. All I had to do then was to push bobby pins into the back of the cap so that I could connect it to my hair there. Figure 3.8 was taken on that first day and shows the cap that I struggled with.

Figure 3.8: Day one, the first-year cap

Source: Hills 1964-7 Scrapbook. I am standing on the right in the photo

I was very grateful to Jill for her help and told her that she had saved my life. With that problem resolved I join the others in my group and we headed to the hospital for breakfast. As we walked across the courtyard I was also grateful to be able to wrap the red cape tightly around my shoulders and arms because the uniform only had short sleeves and there was a nip in the air. After breakfast, we all presented ourselves at 7.55 am to Matron in her office.

When I look now at the photo taken on our first day, of myself and two others in my group, I realise that I had made the best of a very difficult activity of anchoring the cap in place on my head. I don't think that the first-year nursing cap was ever intended to make any of us look attractive. It was a symbol of being a new trainee and it helped to situate us in the pecking order of the hospital hierarchy. Each of the differently styled caps of the first, second and

third year trainees used in that hospital helped to define each of us as a trainee nurse, and over the years of my training differentiated the various years that I had achieved on my journey to becoming a trained (registered) nurse.

When I was standing in front of Matron's desk on that first morning with my new nursing trainee friends, all of us in our new crisp uniforms, I was feeling a little more confident with my cap held firmly in place. When Matron referred to us as nurses I again experienced the thrill of the previous evening. I felt like I had joined the '*sisterhood*' and belonged, albeit to a sisterhood bound by rules and regulations.

RULES TO LEARN BY

After the meeting with Matron on that first morning we were taken by the Principal Tutor Sister. (She is called the Principal for the rest of this section) to the training school. She walked us to the street behind the hospital to an old mansion that was being used at that time as both a home for sisters who '*lived-in*' and as the training school, (see Figure 3.9). The school was in the two attic rooms on the second floor of the house. After entering the house, we followed the Principal up the main staircase of the large old building. I looked

Figure 3.9: Classrooms were in the attic rooms of this house.

48 *"Berkburn". Purchased in 1950 for use as a School of Nursing and as a home for student nurses, it was later used for accommodation for trained nursing staff.*

Berkburn was demolished in 1975 to enable the Hazeldean Nursing Home for the Frail Aged to be built.

Source: Strahan (1991, p. 142).

behind me down into the large entrance and across to the door into the larger room that I had glimpsed to the right as we had entered the house. The house was larger than any house that I had been in previously, reminding me of the homes in movies where rich people lived.

The Principal told us not to loiter downstairs when we came to the house for class in the future. She instructed us to always go straight upstairs because the sisters who worked at the hospital slept on the second floor and their lounge and kitchen were on the ground floor. We followed the Principal into one of two attic rooms at the top of the stairs.

> *As I followed the Principal into the room and looked around I was reminded of the old rooms that were used as the boarder refectory of the school and had been part of the convent where I had spent the last two years of high school. However, even though the accommodation there had been old, we had good classrooms. That was not the case with this school. I was disappointed because I had thought that we would have had a better room to have classes than the cold dark room I saw. I was pleased when told that this situation would not continue for long because there was a new training school being built in the hospital grounds adjacent to the nurses' home.*

I noticed that the windows of these rooms were very small and that they did not admit much light into the room. I looked around the room and saw a large blackboard propped on an easel and a table with a chair behind it facing into the room. There were six small student desks and chairs neatly arranged in two rows facing the blackboard. Apart from the drab surroundings it was a very dark and cold atmosphere which meant that as I sat there I got very cold and, because my arms were not covered, I had to draw my short red cape over my arms again, but it didn't help me very much.

It appears that I was not the only person concerned about our living and learning conditions. Strahan (1991, p. 142) wrote about the addition of new facilities in 1964 under the heading, '*The Hospital strives to improve the teaching environment*' and revealed:

> The hospital took several ameliorative measures to attempt to answer criticism of its training facilities. In 1964, a new teaching department attached to *Penrose House* (the nurses' home) was opened, and training procedures were recast to improve both their educational content and working conditions

Strahan, (1991, p. 142) explained that following this development classes were expected to '… commence there before the end of 1964.' Unfortunately, the school did not move until December, so we had to cope with the cold and dark conditions until after we had completed our Preliminary Training School (PTS). When the new facilities did open all the students were ecstatic. Not only did we have gleaming new classrooms, but we didn't have to walk out in the weather to get to them because they were built at the end of the first-floor corridor of the Nurses' Home.

Before we had a chance to catch our breath on the first morning the Principal instructed us to find a seat and to sit down. When we were seated she commenced the first lecture of our PTS program, telling us what our learning responsibilities would be for the next eight weeks, until 3rd November. We spent most of the eight weeks of PTS in the classroom learning various subjects such as General Nursing, Practical Skills, Anatomy and Physiology and Hygiene. The Principal explained that at the completion of PTS there would be a written examination for all subjects as well as a practical test to ascertain our skills of setting up for, and doing, nursing procedures. If we passed that examination and graduated from PTS we would be rostered to one of the wards as a trainee member of the nursing staff. We were also told that we would spend some mornings in the last two weeks being supervised by a tutor to practice our nursing skills on patients in the wards. According to McCoppin and Gardner (1994, p. 20):

> Preliminary Training School (PTS) was first introduced to nursing education in Australia in the 1930s. In Victoria, the first PTS School was established at the Melbourne Hospital in response

to the request made by the ward sisters (Registered Nurses) who worked with students when they were allocated to the wards. The Sisters thought that the students did not have enough practical training before going to work on the wards.

During our first day in the classroom Sister asked us to write a short essay about why we wanted to become nurses. It is included below as Figure 3.10.

Figure 3.10: Essay - Why I want to be a nurse

My main reason for wanting to become a nurse is that I have a great wish to help others. By becoming a nurse, I feel I am accomplishing this fact, as I can help sick and aged people through their suffering hours with the help of the knowledge I gain in my training.

Most people are placed on earth for a special reason. This usually comes under the heading of a Calling. Just as others take a religious life, or engineering as their calling, they find there is nothing else they can do as well. I wish to feel that I am accomplishing something in this life and that I am not just taking and not giving in return. People are wonderful creatures and I like mixing with them. They are also interesting. The human body is an interesting and mysterious thing, and to have even a small knowledge of it would be to me something very wonderful.

When I finish my three-year general training, I wish to do my midwifery training, in doing so I will have received 2 certificates. This I hope will enable me to travel if not I hope to take a position in a country hospital.

Source: Hills 1964-7 Scrapbook

With very little real understanding of what to expect during my training I wrote down my reasons based on my ideas about what I thought nursing was going to be about for me at that time and into the future.

I never did undertake the midwifery training and rather than travel after graduating I took up a position as a registered nurse in a country hospital. I spent many years during my career working in country hospitals, my attraction for which had its genesis in my childhood.

My student records show that some of the subjects that we studied in PTS were Introductory Anatomy and Physiology, Hygiene and General Nursing, including bandaging and basic nursing skills. Also included were twenty-six hours of patient sponging on the wards and three hours dedicated to learning invalid cookery.

MORAL CONTROL OVER STUDENTS' LIVES

When I was training I was both a student and an employee of the hospital. As a seventeen-year old adolescent girl in the 1960s in Australia I was underage and would not come of age until I was twenty-one years old. Until I came of age my parents were my guardians and when I took up the position as a student in the hospital Matron not only assumed responsibility for me as an employee but also for my moral wellbeing - consequently my moral wellbeing was well and truly being looked after! Because I was underage that was understandable, but Matron also assumed responsibility for trainee nurses who were of age.

This moral responsibility for students included controlling our social as well as our work lives. Rules such as those which I was told about by the Deputy Matron on my first day were among the many that controlled my life during my training.

This control was particularly evident during the first six months of my training when I was categorized as a probationer. I knew that I would have to conform to all the expectations and rules

when I was a probationer. Those expectations didn't stop with the completion of my probation because the contract that I had agreed to and signed in February 1965, set out a clear set of expectations for my continued conditions of appointment. A copy of the conditions of appointment is at Figure 3.11.

Figure 3.11: Conditions of appointment

Conditions of Appointment

All questions must be fully and carefully answered.

Women between the ages of 17 and 32 are eligible for appointment as pupil nurses, and a personal interview with the Matron is necessary. The minimum standard of education is the Merit Certificate of the Education Department of Victoria.

The term of a Pupil Nurse's training is three years and during the first three months she will be on probation only. Pupil Nurses are received on the distinct understanding that they will complete the full term of their training. They may be allowed to withdraw on approved grounds.

Probationers will be liable to be discharged at any time during probation for misbehaviour, unsuitability, inefficiency, neglect of duty, breach of rules or agreement.

Pupil Nurses are under authority of, and will do duty as directed by Matron. They may be suspended by the Matron and discharged by the Committee for any of the causes mentioned above.

Salary commences from date of commencing probation, and will be at the rate of ...., ..., ... per week for each successive year.

Probationers who are accepted at the end of probation must enter into and sign an agreement on the following term.

To the Committee of the Williamstown Hospital,

I, Lesley Mary Hills

having now served as probationer at the Hospital for six months, am satisfied that I am able to fulfil, and agree to complete the terms of my training, 3 years, irrespective of sick leave.

I agree to submit, and conform cheerfully, without demur, to the rules and regulations of the Hospital, whether the same have been made before or after my admission, and to obey orders. I recognise the right of the Hospital Committee to dispense with my services at once should I commit any breach of my agreement or misconduct myself.

Signed Lesley M Hills

Date 2-3-'65

Source: Transcribed from the personal training documents found in the hospital archive 2010

Considering that I was underage and required guardianship it was interesting to note that I alone signed this document prior to my coming of age. The document was not countersigned by either of my parents or Matron. The control over the student's life was designed to act as guidance for us to behave in a moral and ethical manner.

The behaviour expected of me as a trainee nurse was both like and unlike many of the fiction stories about how nurses lived and acted as portrayed by the film makers and authors of the era and which were seen regularly in the picture theatres and on television at that time. In such media society is confronted with stereotypes and according to Kalisch, Kalisch and Clinton (1981, p. 358) … television is a socializing force and moulder of ideas.'

Figure 3.12: UK movie poster of 'Carry on Nurse'

Source: http://www.imdb.com/title/tt0051452

The fiction of the day tended to depict the nurse as constantly carrying and delivering bedpans, rubbing backs and taking temperatures and taking orders from their superiors the doctors, with other more senior nurses often in promiscuous romantic liaisons. Figure 3.12 is an example of the way in which nurses were often depicted in the media.

Kalisch, Kalisch and Clinton (1981, p. 359), when exploring the perceptions of the public about nursing, referred to a study undertaken in 1975 in which recipients believed that 'Nurse characters are much less powerful, authoritative, and knowledgeable than physicians, and nurses are shown for the most part in subservient positions obeying physicians' orders unquestioningly.' In the outcomes of their study

of 1981 on the portrayal of nurses and nursing over the previous thirty years Kalisch, Kalisch and Clinton (1981, p. 359) found what they believed to be a '… current crisis in communicating the world of nursing to the public.'

The findings by Kalisch, Kalisch and Clinton (1981, p. 359) included:

> … nurses were depicted as working in acute care settings, entering nursing for altruistic reasons, predominantly acting as a resource to other health professionals, not using problem-solving and evaluation skills, deficient in administration abilities, and remiss in providing physical comforting, engaging in expanded role activities, patient education and scholarly endeavours. Since the 1960s the trend to quality of nurse portrayals has been downward.

Although these studies did not relate to contemporary Australian nursing shows many USA television shows are aired in Australia and consequently have the potential to impact on Australian audiences, as do movies made in the USA and Britain. Stanley (2008) gives an example of one British movie '*Carry on Nurse*' that was released in 1959 in which the way nurses were characterised as promiscuous had a significant impact on how nurses were perceived at the time. During my training this attitude continued to prevail.

The perception that nurses were free with their sexual favours had a significant impact on my personal life and caused me a great deal of anguish. I attribute this behaviour to the ideas generated by the media including the '*Carry on*' movies. I did not have a car or drive and usually the young men with whom I went out did and I relied on them for transportation when we were on a date. On returning from a date it was not uncommon for me to have to untangle myself from a young man's unwanted advances that often deteriorated into groping at me and me struggling to get him to listen to me.

> *On more than one occasion my date had assumed that because I went out with him that I would be happy to offer sexual favours; 'You're a nurse you know all about this,' was said to me more than once.*

My response was angry and indignant. I had my own set of rules relating to what I was prepared to do on a date and generally the boy was surprised at my response, especially when I told him I was more interested in having fun than in sexual activities. I rarely went out by myself after the first few experiences of this behaviour. I came to realise that I was safer in a group.

PUSHING THE BOUNDARIES - BREAKING THE RULES

On one Saturday evening in my second year I was sitting with some of my peers who, like me, were lucky to be off duty but not lucky enough to be going out for the evening. We were congregated in the nurses' home lounge-room gossiping and watching television. As usual it seemed like we were waiting for something to happen. That night it did. The phone rang:

'*Does anyone want to go to a ship party?*'

This was not the first time I had heard this call reverberate around the nurses' home. It was quite common for the sailors on the ships that were in dock locally to be looking for nurses to come to one of their parties. Previously I had not gone with the other nurses who went to the parties. I was always worried that I would get into trouble. I knew that if I was seen on the docks I would be at risk of being dismissed from my training. On this evening something changed, and I decided that I would go with the others. I wanted to have fun like them and none of them had been caught before - they seemed to know how to get away with it. I was eighteen and in my second year as a student. I wanted to break out and be like my other friends.

On this evening my friend Jenny said that she would take me in her car if I wanted to go to the party. That was my cue - I would go with her. I felt confident with her because she was older, and I could trust her. Even though I had decided to go the decision caused me a lot of anxiety. I was about to break one of the big rules that controlled the student's life.

I changed into my party clothes and headed off with Jenny and my friends to the dockyards. When we arrived, we walked along the wharf to the ship. A sailor hurried towards us and told us to quickly duck under the gangplank because the captain was bringing his dinner guest down. We didn't wait to be asked a second time and that was fortunate. The captain escorted his guest to her car at the end of the dock. When we saw her back as she walked away from us we all looked at each other in shock.

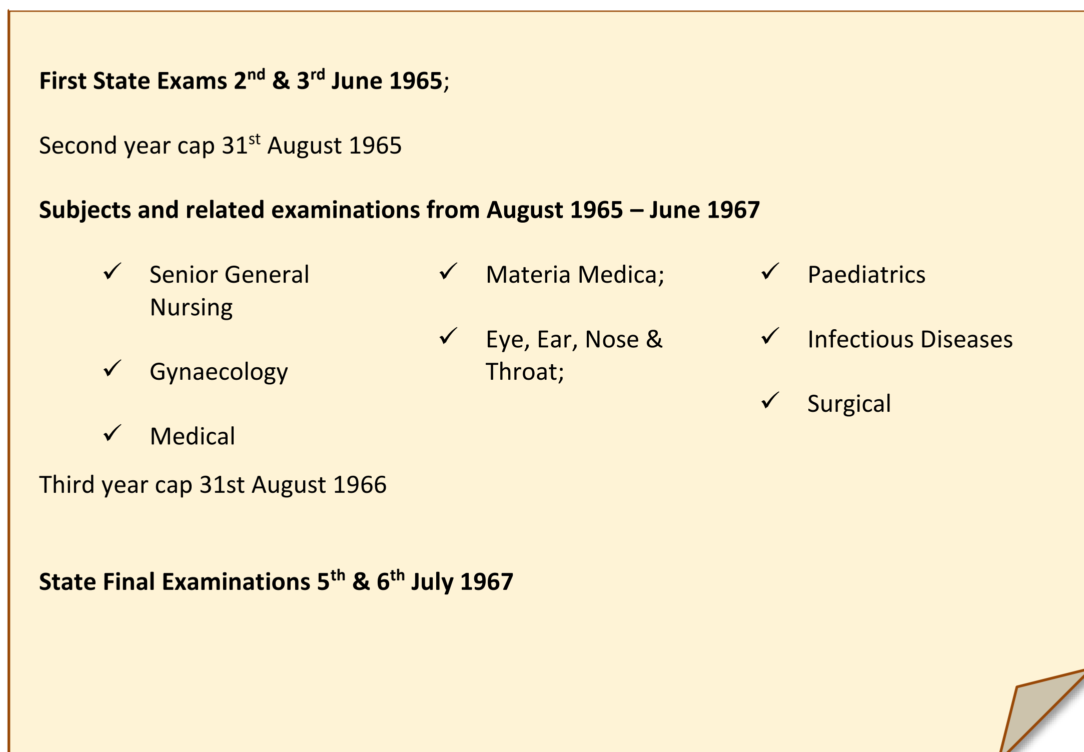
It was Matron! I rushed up the gangplank with the others, anxious not to be seen. I had not only joined the sisterhood, I was a committed member and was breaking one of the rules!

PREPARATION FOR LABOURFORCE

CLASSROOM LEARNING

After PTS I still had many more subjects to learn and examinations to pass before I finished my training. In Figure 3.13 is a list of information taken from my training days (Hills 1964-7 Scrapbook)

Figure 3.13: Subjects remaining following PTS



First State Exams 2nd & 3rd June 1965;

Second year cap 31st August 1965

Subjects and related examinations from August 1965 – June 1967

- ✓ Senior General Nursing
- ✓ Gynaecology
- ✓ Medical
- ✓ Materia Medica;
- ✓ Eye, Ear, Nose & Throat;
- ✓ Paediatrics
- ✓ Infectious Diseases
- ✓ Surgical

Third year cap 31st August 1966

State Final Examinations 5th & 6th July 1967

Source: Hills 1964-7 Scrapbook

showing the remaining subjects to be completed after PTS, including the examinations and milestones that were to be met before I could complete my training. It was a very generalist and medically orientated program run exclusively in the hospital.

Following graduation from PTS most of the classes that I attended were held during the working week outside my rostered ward hours except for two study blocks in which the trainees were given time to prepare for examinations. One was held at the beginning of second year and the other as the two-week preparation time for our final examinations. Among the weekly lectures were the first-year anatomy and physiology doctors' lectures that were held at 7 pm on Tuesday evenings for ten weeks and coincided with the hospital visiting hours of 7 pm-8 pm.

There were various ways in which we were given instruction throughout my training - sometimes in the classroom, others in the practical room and at other times, following learning in the classroom, being taken to the wards to practice on patients. Most teaching was delivered by one or other of the tutors however there were some subjects, including Anatomy and Physiology, that were taught throughout PTS and first year by a local GP. Medicine, Surgery, Paediatrics, Ear, Nose and Throat, Infectious Diseases and Gynaecology were taught by medical specialists who were visiting honorary medical officers to the hospital. My time spent at lectures was documented in my nursing records by Matron. I located them in archive boxes in the hospital store room in 2010. On review of these documents I calculated that classroom teaching for this pre-registration program totalled approximately 800 hours over the three years of my training.

The teaching style of the tutors and doctors when in the classroom was didactic. All of them would sit at the front of the class and lecture directly from the text books or notes. None of the teachers involved had an educational qualification. At times the tutors also wrote copious notes on the blackboard which we then transcribed into our note books. We spent many hours copying notes

from the board into our exercise books while we maintained the polite silence required of us in the classroom. The notes not available in a text book were written up by the various doctors who gave the specialist lectures. These notes were reproduced using a gestetner machine and then stapled together to look like a booklet.

When I was sitting through the lectures, especially those delivered by the doctors, I found my mind wandering. It was disheartening to realise that we were being read to as if we were children, directly from the text book or notes. I found this very difficult because I knew from my experience at school that the only way in which I learnt was to test my ideas by asking questions.

ETHICAL BEHAVIOUR

My first experience of that didactic approach to teaching occurred on that first day of PTS when the Principal introduced us to the behaviour expected of trainee nurses in a lecture that she called Ethical Behaviour. The lecture covering this material was taken from the first chapter of our nursing text book by Doherty, Sirl and Ring (1963) called *Ethics and Hospital Etiquette*. During the lecture I learnt how to address other members of the health care team. As I sat there in my crisp new uniform, listening attentively to the Principal, she told us that it was customary for trainee nurses to stand in the presence of doctors, Matron, sisters and senior trainee nurses. She also explained that we must never speak to a doctor unless he spoke to us first and to stand with hands behind our back when in the presence of doctors and Matron, and always to call doctors '*Sir*'. (Hills 1964-7, Scrapbook)

The Principal gave us this information by reading directly from our text book. The lesson seemed to go on for ever, with her reading and commenting and making notes on the blackboard from time to time. I sat quietly and tried to make sure that my mind did not wander. During the lecture she told us about hospital etiquette and reinforced how important it was for us to be ethical

nurses. She continued to read from the text book and concluded with the words of Doherty, Sirl and Ring (1963, p. 3), 'By the observation of **Hospital Etiquette** is meant doing the right thing as the hospital does it'. She then introduced us to the First International Code of Ethics adopted at the 10th Quadrennial Congress of the International Council of Nurses in San Paola, 1953 (Doherty, Sirl & Ring 1963). The information in this text concisely encouraged the student to be polite, thoughtful of patients, relatives and the public, always '… ensuring their confidence will be respected' (Doherty, Sirl & Ring 1963, pp. 1-3). The rest of the information covered the importance of **'…** loyalty, and a cheerful co-operation with all those whom the nurse comes in contact' (Doherty, Sirl & Ring 1963, pp. 1-3).

By the time that we got to the second chapter on that same day the scene was well established for the expected behaviour of trainees as reinforced in the text book under the heading '*Advice to Student Nurses*'. This section covered deportment, serenity, sympathy, tact and understanding, the spiritual relationship, observation, truthfulness, accuracy and reliability, obedience, punctuality, orderliness, economy, cleanliness, and the care of the nurse's hands (Doherty, Sirl & Ring 1963, pp. 5-7). This chapter also described how nurses should apply themselves to study, revision, preparation for examination including oral or viva voce examinations and practical examination (Doherty, Sirl & Ring 1963, pp. 7-12).

> I was learning that the behaviour expected of me by my parents and school teachers was the same as was expected of me as a trainee. As a result, I set out in those early days to apply myself to study and to make sure that I behaved in the way that was expected of me, and without question. I recognised that all I had to do was to learn all the rules around nursing work and I would be successful. However, with all the rules swimming around in my head, I wondered when we would learn about how to do nursing care.

The first lectures of the morning set the scene for the rest of the next three years, I learnt to sit quietly, look interested and write like fury so that I could be sure to have all the information to study. Even though I was keen to be a good nurse in those early days I struggled to remain quiet and attentive in this controlling environment, given my penchant for wanting to ask questions so that I could clarify the new ideas that I was learning. When I did ask questions the tutors always referred me back to the text books for the answers. This had the effect of my conforming to the expectations and becoming a passive receiver of information.

At lunch time on the first day I left the classroom with my new peers, feeling very confused about the ethical rules that we had learnt about that morning. I could understand why we were expected to address our superiors in a polite manner, however I was really confused about the issue of being told that any nurses found sleeping in a room with another nurse would be instantly dismissed. Even though I could not understand why the Principal was talking about this situation I did not think that I would ever want to share a bed with another nurse because for the first time in my life I had a room of my own. I had spent my childhood sleeping in the same bed as my sister and when we visited my cousins' homes we often had to sleep at the bottom of their bed, top and tail my mother called it. I mentioned my confusion to my friends who told me that the sister was talking about the concern that in some nurses' homes women had sexual relationships with other women. This was both very confusing and confronting for me. I remember my confusion as I walked along to lunch however, because I was loath to feel stupid in front of my peers, I decided not to discuss it further with them. My childhood had been somewhat sheltered and consequently I did not learn until much later about homosexuality and lesbians.

NURSING TASK RULES

When we arrived back after lunch we were shown the practical room where we were to learn about general nursing practice. I was really pleased that we would be learning how to be a nurse here. The room looked like the room across the hall where we had been that morning, but rather than desks it held two hospital beds with sheet-covered mannequins lying in them to be used as substitute patients. When the tutors taught care of patients they demonstrated many clinical procedures on one of the mannequins, procedures which we then practiced on the mannequins to gain competency.

Learning about new clinical procedures was a routine that I became accustomed to quickly. Firstly, we trainees were expected to read about the procedure in our text book so that we could learn the names of the equipment required for each of the procedures. After this the tutor sister would draw a diagram on the blackboard of the trolley that was always used to carry the equipment for a procedure, and then drawing the equipment and instruments onto the trolley showing the exact place where they were to be positioned either on the top or bottom of the trolley. We were then required to draw the picture into our exercise books. There were very specific places for all pieces of equipment with metal kidney dishes, bowls, jugs and instruments to be placed precisely on the trolley. It was impressed on us at the time that the rules for procedures were considered of great importance. I took the time to transcribe them into my exercise book knowing that it would be tested in the PTS examination.

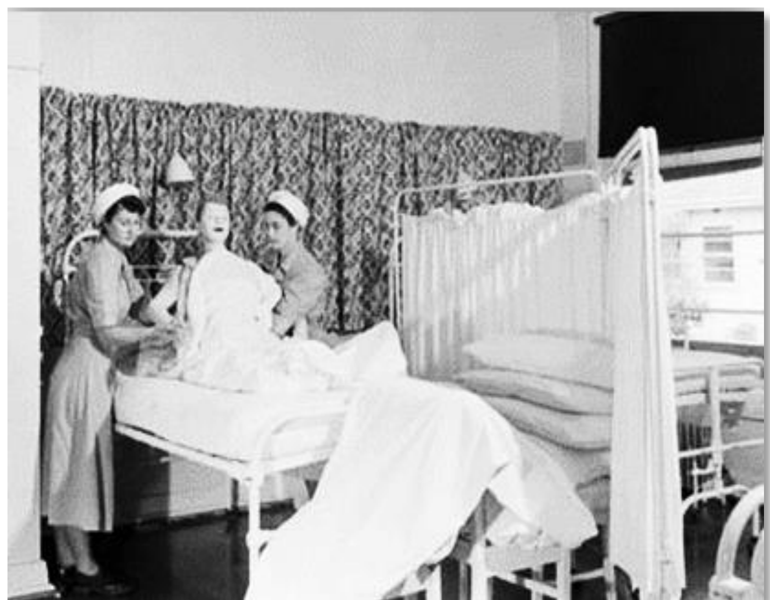
After watching the Principal demonstrate a procedure for the first time we were instructed to practice under her watchful eye. Later in the program, when we went to work in the wards, we were required to practice on patients under the supervision of one of the ward sisters until we were considered to have mastered the procedure. When I did practice on patients on the ward and eventually accomplished the standard required it was a great feeling and I was quick to

produce the Victorian Nursing Council procedure book and to open it to the correct page, asking the sister who had observed me to sign the book to confirm that I had completed the activity satisfactorily. That procedure book was an important document for each of us to maintain because at the end of our training we were required to send the completed book to the Victorian Nursing Council. The Council used the book as proof that each trainee in Victoria had completed the tasks considered essential for a nurse seeking registration. Appendix 2 is a copy of some pages from this procedure book.

Bed making

In the bed making session I was surprised to learn, as I read the General Nursing text book by Doherty, Sirl and Ring (1963), about the many different types of beds that we needed to learn about. They included how to make and strip an unoccupied bed; to make an admission bed; bed for amputation of the leg; fracture bed for upper extremity and one for lower extremity; operation bed; a bed using a bed cradle; a bed for a patient with cardiac failure; a bed for an unconscious patient; an epileptic patient and how to strip a bed for airing. Many of the beds were similar except for the way in which the pillows were placed, and special requirements such as kidney dishes, bowls and instruments that were also required to be placed on the patient's locker when these beds were made. I had thought that I would easily be able to do bed making because I had been

Figure 3.14: Nursing students – Learning bed making, 1965



Source: National Library Canberra, image no. A1805, CU1-76/13 Barcode 11868766

taught by my mother from an early age to do hospital corners. However, she had never told me about all the various types of beds required for different conditions. Figure 3.14 was accessed from the National Library archive and shows nurses learning in a similar manner to what I did to do bed making with a mannequin representing a patient in the bed.

Figure 3.15: General rules for bed making

Bed making – General Rules

An Unoccupied Bed

Requirements:

2 long sheets 2 or more blankets 1 draw sheet 1 quilt
1 draw mackintosh 1 pillow and case or more as required

Procedure:

The locker and chair are moved away from, but kept in line with, the head of the bed.

The mattress is turned where necessary, inspected and pushed well up to the head of the bed.

The bottom Sheet is placed centre fold to centre of bed and unfolded with the hem right side uppermost,

- 12 inches are first tucked in at the top, and the near corner mitred.
- The sheet is drawn straight and taut and tucked under the foot.
- The near corner is mitred and the side tucked in.

The draw mackintosh should extend from the lower border of the pillow to beneath the patient's knees.
The draw sheet is placed on the centre of bed, completely covering the draw mackintosh both are separately, firmly and smoothly tucked in.
The nurse then walks around the bed, turns back the draw sheet and mackintosh, and, commencing at the head of ben, repeats the procedure with the bottom sheet, draw mackintosh and sheet.
The top sheet is then put on, wrong side up, allowing 18" to turn over the blankets, and the fold at the topic to be 12" from head of the bed. The sheet is tucked under the mattress at the foot, the corners mitred, and the sides tucked in half way up.
The first blanket is then placed on 12" from the head of the bed, the side turned about 4" on to bed at head and the surplus at the foot turned on to itself and the side tucked in about halfway. (…further information is given for the second blanket)
The quilt is next put on and arranged according to the methods used in the hospital, and the top sheet is turned over evenly.
The pillow is place neatly on the bed, the open end of the case away from the main door.

The locker and chair are replaced, the bedside left tidy, and floor free from dust.
If in a ward, the bed is inspected to see that it is in line with the others

Source: Doherty, Sirl & Ring 1963 pp 15-6

The general rules of bed making, some of which are described in the box at Figure 3.15, takes up twenty pages in the Modern Practical Nursing Procedures text by Doherty, Sirl and Ring (1963, pp. 24-43), which was to become the practice bible for the first years of my nursing career.

We were instructed to place the pillows on the bed so that the opening faced away from the door. When I asked why this was done I was told that it prevented the dust from getting into the pillow.

> *This response caused me some confusion however I did not ask the obvious question, how the opening of the pillow case facing away from the door impacted on how or if dust would get into the pillow case in any way if it was faced the other way. I had learnt by now that if there was a rule to be learnt, learn it and don't ask why!*

A rule not included in the text book was one that I heard many times over the next three years. When we had finished the bed making for the day we had to make sure that the wheels on all the beds and the over-bed tables in the ward were always facing in the same direction. I forgot this only once and after the charge sister had chastised me loudly, so that all the patients and other nurses could hear, I never forgot again. After learning about the vagaries of bed making we quickly graduated to learning about our cleaning role.

Cleaning

There were many aspects to the types of cleaning that we had to learn, and which trainees needed to undertake. These included the rules on how to damp dust the ward and patient area, how to bathe a patient in bed, how to set up for and clean up after a patient wound dressing or other patient care procedures, and how to assist a patient to use and then after use to clean the metal bedpans, urinals and/or sputum mugs.

I, like my peers, found that my pharyngeal reflex worked exceptionally well when I emptied a full sputum mug into the pan sluice. It was common practice for some men in those days to expectorate in the street and to prevent them spitting on the ward floor, which I had seen done often, we gave them a sputum mug. To empty a bedpan of faeces paled into insignificance in the face of a sputum mug full of sputum. Most male patients were given a sputum mug to expectorate into when in hospital even when they did not have a respiratory disease.

> *I felt very comfortable and confident learning about cleaning and bedmaking. I had done at lot of cleaning as I was growing up so was quite used to the idea of being involved in this activity, both at school and at home.*

Cleaning was part of the Hygiene subject that we covered in PTS and we had many opportunities to practice on the wards during that time. The excerpt about Hospital Housekeeping is taken from Chapter three of our text book (Doherty, Sirl & Ring 1963, pp. 13-4) which specified some of the rules and reinforced that in future one of my responsibilities would be to supervise the cleaning in the ward. They wrote:

> It is to the advantage of the student nurse to have a working knowledge of domestic affairs, for when qualified, she will have to supervise the work of maids and assess the amount of time required for its satisfactory performance.

Doherty, Sirl and Ring (1963, pp. 13-4) continued by introducing us to the rationale for cleaning which had a focus on good patient care:

> Extensive investigation has been carried out within recent years in connection with the control of airborne infections in hospital wards, such as diseases of the respiratory tract. It seems generally accepted that there are three main methods of dealing with this problem:
>
> 1. The treatment of floors, ledges, surfaces, etc, to prevent spread of dust.
>
> 2. The treatment of blankets, bedding, bed linen and the patients' garments.
>
> 3. The treatment of the air by ultra violet rays and chemical vapours

> Dusting: No dry dusting should ever be done. Dusters must be damped or oiled and must not be washed in kitchen sinks or ward hand-basins but boiled once daily. Before commencing to dust the area must be cleared. When dusting walls, furniture, etc, the dusting should be done from above downwards.

The information about wet dusting walls was relevant to me when I did my second- and third-year rotations in the operating theatre. At that time, I wielded a large wet mop up and down the walls of the theatre rooms at the beginning and the end of each shift. Mopping the walls meant a quiet time for me before and after a busy day working in the operating theatre. It was a great time for daydreaming about life outside of work.

That the strong focus on cleaning was evident in the nursing courses was of concern to many nurse leaders, among them Jayawardena (1961) and members of the Royal Victorian College of Nursing (RVCN), who were proposing that nurses should be released from the mundane cleaning and related domestic activities and concentrate on patient care, leaving cleaning to others. Jayawardena (1961, p. 306) wrote that:

> Nurses and nurse educators need to think more about the changes that are accruing in bed side care with the increase in technical care. If nurses are to be able to engage in these new activities effectively they need to eliminate some the activities that could be done by others thus reducing the quantity of activity to one of quality.

Practicing on the wards

In the last four weeks of PTS the classroom work was interspersed with some practice in the wards under the supervision of the tutor. We did bed making and cleaning and tidying the ward, sponging (bed bath) patients in bed, back-care, bedmaking, feeding patients, doing patient observations including blood pressure, pulse, respirations and temperature and urine testing. After I had completed the tasks for the day I undertook ward cleaning and tidying to ensure that the patient environment met the hospital hygiene expectations. When there was extra time the tutor showed us patient notes and explained how they were used, again explaining more rules, this time regarding how to work from doctor’s orders.

The way in which we learnt in PTS was very like the experience of nurses in the 1950s. Porter (1977, p. 3) in a speech at a conference in 1973 as the Chief Nurse of South Australia, shared some of her memories of being a student in the 1950s, describing the experience of herself and her peers:

> During that time, we spent a couple of hours a day on the wards learning to sponge patients; we spent time in the classroom learning to take temperatures; position patients; make beds and then we were thrown to the wolves and the poor unsuspecting patients. Because we wore a uniform, they thought that we knew everything.

Sheean (1995, pp.5-6), when exploring the role of the nurse and the education approaches of that period, recognised the domestic nature of the nursing role that we were learning, and wrote of that time:

> The nursing education offered in the hospital-based programs resulted in a firmly established role differentiation in hospitals, where nurses were poorly educated doctors' handmaidens. Doctors filled the scientific clinical role, and nurses provided the domestic and hygiene role, and a model for nursing education was firmly established.

As the time drew near for the PTS examinations I and the rest of my group spent most of our off-duty time studying. I was amazed by how much we had to learn in a very short time. I was also concerned about my capacity to pass the examinations that would cover the material we had been taught.

Bandaging

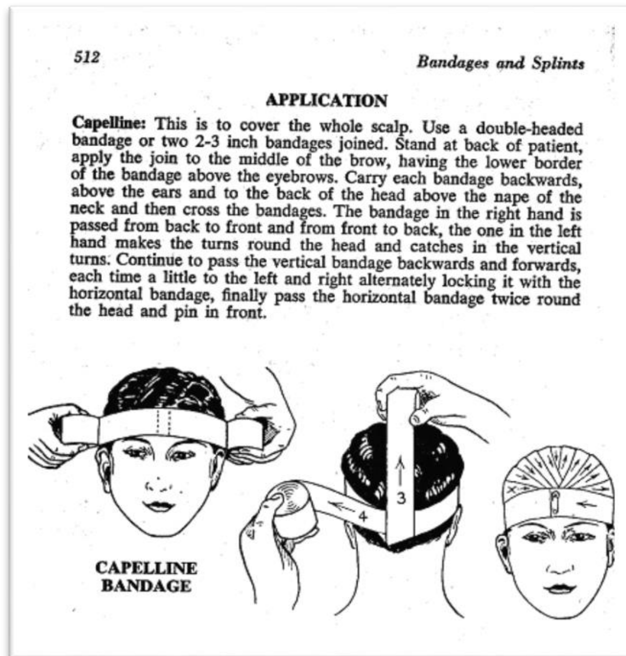
One day I was with the other three trainees in my group studying in Barbara's bedroom. We took up a great deal of space in the small bedroom. Annette and I were sitting on the floor at the side of the bed, Barbara was seated on the foot stool and Jenny was lying on the bed. We had been studying all weekend. On this day, rather than go home to our families for the weekend, we all stayed back at the nurses' home so that we could study together to prepare for the PTS examination. During the weekend we had been dipping into all the subjects we had done during PTS and which we were going to be tested on - Anatomy and Physiology, General Nursing Theory,

Hygiene as well as General Nursing Practice including bandaging. At one point in the afternoon we were trying to work out some of the rudiments of introductory anatomy and physiology and I was starting to get very restless because it all seemed insurmountable. I was very concerned that I didn't have enough knowledge to get the 65% pass mark required for each of the subjects. I complained to my friends, who reassured me and said that we would all make it and encouraged me to keep studying. It was good to have friends to lean on at that time.

I thought to myself that they had more confidence in me than I had in myself. I knew that I had to get through these exams the first time or I would have to leave the course. At one point my confidence picked up because suddenly, after going over and over the system, I understood the pyramidal track of the nervous system. This knowledge had been evading me since Sister had first introduced us to the nervous system. Even with this new understanding, as time went on, I became restless again and was looking for a distraction from the anatomy and physiology. I asked my friend Barbara to show me again how to do a Capelline head bandage. The bandage was used to hold a dressing in place on the scalp. This was one of the bandages that we had to learn to apply to a patient's head and had been told it could be on our practical examination. I always felt like I was all fingers and thumbs when I practiced this bandage which, although I had never seen used on a patient, I had seen often used as a prop in a movie.

Barbara's previous job had been as a nurses' aide in the dressing stations of another hospital. She had a lot of experience with the complex bandages we were required to use on our patients. The Capelline was the most complicated of the bandages that we had to learn, a picture of which and the directions were in our general nursing textbook by Doherty, Sirl and Ring (1963, p. 512) see Figure 3.16).

Figure 3.16: Instructions for Capelline bandage



512 *Bandages and Splints*

APPLICATION

Capelline: This is to cover the whole scalp. Use a double-headed bandage or two 2-3 inch bandages joined. Stand at back of patient, apply the join to the middle of the brow, having the lower border of the bandage above the eyebrows. Carry each bandage backwards, above the ears and to the back of the head above the nape of the neck and then cross the bandages. The bandage in the right hand is passed from back to front and from front to back, the one in the left hand makes the turns round the head and catches in the vertical turns. Continue to pass the vertical bandage backwards and forwards, each time a little to the left and right alternately locking it with the horizontal bandage, finally pass the horizontal bandage twice round the head and pin in front.

Source: Doherty, Sirl & Ring 1963, p. 512

When I did the Capelline bandage I felt as though my hands would never coordinate and I thought that without practice I would drop the bandage during the examination. I believed that I really needed some practice in this skill. I had experienced the exasperation of the tutor previously when he had hit my hands with a heavy set of chetle forceps when I dropped the bandage and at another time he pulled at the bandage and when the over lapping edges moved he shouted at me saying that I was useless. This behaviour of the tutor was common when we practiced procedures. His presence towering over me made me nervous, but I didn't feel able to do anything about it, so my response was to find ways to avoid being the spectacle.

I ended that day of study quite happy because at last I had successfully completed the complicated bandaging procedure without dropping the bandages. Given the time spent learning this task I never used it again, not

even for the examination. I was examined on the collar and cuff sling in the PTS examination.

Studying for the PTS examination must have worked positively for me because for the first and last time in my educational experience I not only passed all the subjects but came top of the class as well. This was a moment of pride for me and galvanised my commitment to completing the course.

ROSTERED TO THE LABOURFORCE

READY FOR WARD WORK

I called out excitedly to my friend Annette on the day I received my PTS examination results shouting words like: *I can't believe it. I have passed PTS. I never thought that I would do it!* Annette had just returned to the nurse's home after having had her days off at home with her parents. I had returned earlier in the day and was waiting in the nurses' lounge for my friends after I had found the letter from Matron telling me that I had passed the examination and informing me of my roster from the next day. When I read the letter from Matron I couldn't believe that, for the first time in my life, I had topped a class. Annette was smiling and holding up a piece of paper as she entered the room and told me that she had passed as well. We found out later that each of us in the group had passed and shared our pleasure at being real first-year nurses at last.

While we waited for our friends Annette and I talked about the wards we were going to be working on from the next day. I was going to work in the female medical ward in the morning. All this excitement to be able to work on the wards and to be a real nurse was somewhat short lived when I realised that the roster for working on the wards combined with the program of study and lectures was going to make for a very limited social or family life. The fortnightly roster was the controlling factor and would be for the next three years. Any social commitments would come a very poor last on my agenda.

After those first two months in PTS learning the rudiments of the nursing role I was rostered to the ward as a first-year nurse. In those days it usually meant that I was rostered on split shifts for five days, 6.30 am to 10 am then 4 pm to 9.30 pm with half an hour for lunch or dinner. The split or broken shift was designed in a way that ensured that the junior nurse was available at each end of the day. This meant that they could do both the cleaning and tidying and be available to assist the other nurses in giving the patients their bed baths and related care in the morning and to settle them down to sleep in the evening.

At the end of each long day I had to drag myself off duty late because no matter what else had happened on the shift, all the tasks on the ward allocation list had to be completed. The shift work and related studying meant that I was often extremely tired. My experience of working broken shifts was not dissimilar to the experience of students in South Australia in the same era who, '… were dealing with the long working hours and broken shifts in the hospitals', according to Hall (2010, p. 138) in a thesis about the history of regulation of nursing in South Australia.

My first roster was reflective of my hours of work for the next eighteen months that I spent as a junior trainee except when I worked on night duty. I was not happy with this first roster because I had been rostered to do six split shifts and would only be having one day off in the following week with a late shift on the day after. The roster looked the same for the next month. I was concerned because I knew that on the evening before I had my day off I would not finish work until at least 9 pm. This meant that if I wanted to spend at least one day at home I would have to travel home on the bus through the suburbs of Melbourne quite late at night.

During my first and second years, prior to my father's death and whenever I had some time off, I would go home to my parents. On these occasions I would quickly leave the ward after I was released from duty and go to the nurses' home to change. With at least one text book under my

arm I would then catch the bus to take me home. Because every minute was precious I would spend the hour that it took to get home on the bus to do some study from one of my text books.

> *The family would often comment that they wondered if I thought I could learn by osmosis given that I always had a text book under my arm when I arrived home.*
>
> *Following the death of my father, my mother and my siblings returned to the town in regional NSW where her parents lived, and where she had grown up. It was a sad and lonely time for me. On the rare occasions on which I could get two days off in a row and had saved enough money I would travel home on the train to see my mother and brothers and sister.*
>
> *The new idea of being rostered to the wards and having to accept whatever was dealt out, no matter what I wanted to do with my social life, made me realise quickly that while I had thought that PTS was constraining, the rest of my training would be more so, especially when I wanted a day off for a special occasion. On the rare occasions for which I wanted a specific day off I needed to apply to Matron or her deputy well in advance. However, it did not matter how far in advance that I made my request, it was never assured. I had this experience when I was invited to attend my cousin's wedding, which was to be held on a Saturday in Hobart. Eight weeks before the event I applied to have the weekend off. The Deputy Matron refused the request because there was a staff shortage and therefore it was not possible to be allocated two days off in a row. I was very disappointed but accepted the outcome.*

Some weeks after applying for the time off I had an emergency appendectomy. I returned home to recuperate after the surgery. When I was packing to go home on the train to stay with my mother, who now lived in regional New South Wales, the Deputy Matron came to visit me in the ward

room. I had been granted four weeks of sick leave by my doctor, and the Deputy Matron mentioned to me that I would now be able to go to the wedding. I was surprised that it was on her mind as I hadn't even realised at that point that the weekend of the wedding would fall in the last days of my sick leave. At the time I remember feeling as though she was accusing me of setting up the opportunity to attend the wedding. She appeared to me to be indignant that I would be able to attend after all.

ON THE WARDS AT LAST

On the first day as a trainee rostered to the ward I entered it with some trepidation, wondering what the unknown would be like. As I entered and looked around I saw a large room with beds down either side and in the distance at the end of the ward there was an opening which, I was to learn later, led firstly to a single room and then off to the right down a short corridor into what was the pan room. To the left down a similar corridor was a small treatment room where all the equipment was held, and which was used for the various patient care tasks such as wound dressings. Behind me at the entrance was an office signposted as '*Sisters Station*' where the ward administration was done as well as where the dangerous drugs were held in a locked cupboard.

Figure 3.17: The female ward in 1920

35 *The Female Ward, 1920. The Ward was opened in 1917 with 13 beds. In 1986 it was converted to provide a Short Stay Unit, with a nurses' station and eleven inpatient beds. The Short Stay Unit operates from Monday to Friday, and accommodates adult male and female patients undergoing surgical procedures as day patients or as relatively short stay patients.*

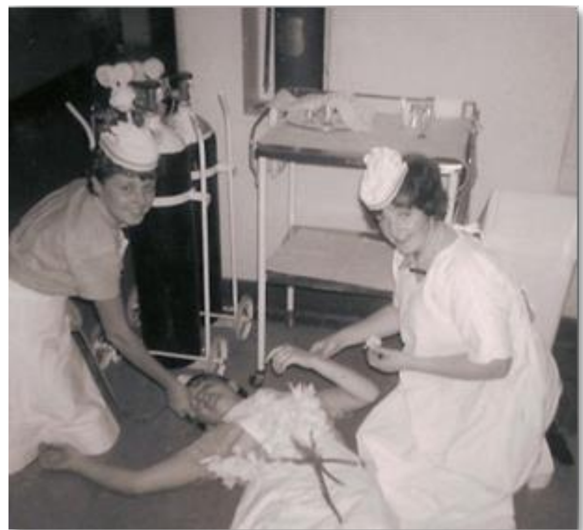
Source: Strahan (1991, p. 16)

In Figure 3.17 is a photograph of the ward taken in 1920, three years after it was first opened. I first saw this photograph in the book that I was shown in 2010 when I visited the hospital to look for material in the archives. The picture depicts nurses standing in the female public ward of that hospital in the 1920s. I could see that not much had changed between the 1920s and when I first worked in the ward as a trainee nurse in 1964. The ward environment looked very similar however there were some small differences, firstly in the way the nurses were dressed and secondly, the nature of the patient privacy curtains.

The nurses in the 1920s picture are wearing longer uniforms than those I wore and a different styled nursing cap that completely covered their hair. The patient bed curtains are on portable frames and located at one end of the ward, ready for the nurses when they needed to move them around the patients' beds. By the 1960s, there were still some portable patient curtains available but most patient beds had curtains around them hanging from the ceiling.

There appears to be no equipment apart from the beds or bedside lockers available for patient care or comfort in the ward of the 1920s picture. Not much had changed in the equipment located in the ward by the time I started my training in 1964, other than each patient's bed having an over-bed table and a chair as well. There were also portable oxygen cylinders available and located outside the patient rooms by 1964. There is an oxygen cylinder on a trolley and a medication trolley shown in Figure 3.18. When a patient suffered respiratory distress and needed oxygen the nurses pushed an oxygen cylinder into the patient room to the distressed patient.

Figure 3.18: Hi-jinx on night duty



Source: Hills 1964-7 Scrapbook.

Light relief spending Christmas time on second year night duty; I was with two third year students out of the view of the night sister supervisor.

As well as the similar architecture, nursing history shows that there was also little difference in the way in which the nurses of the 1920s and my contemporaries and I in the 1960s worked and were educated in the hospital-based nursing programs in Australia. Russell (1990) explored the evolution of contemporary nursing education, explaining Florence Nightingale's influence in shaping a better opportunity for nursing care of the sick, and that the system of hospital-based training that had commenced at the time of Florence Nightingale had remained in place for nearly one hundred years.

During the period of my nurse training, which covered the period August 1964 to September 1967, I undertook the required learning as an employee of the hospital combining a working life with a learning life, and life itself. For three years my life was in the hands of Matron and the Principal who dictated hours of work, my classroom time and when and where it was acceptable to spend most of my time after working hours. For us there was little time to have fun.

CHEAP UNQUALIFIED LABOUR

The teamwork approach that the peers in my group and I had agreed at the commencement of our training fortunately extended even further in our small school. Generally, sisters were only rostered on Monday to Friday in the morning and at some other times when they were the shift supervisor. Consequently, the responsibility for shift leadership on the wards was often placed on trainees. Very early in our training the members of my group recognised that we needed each other to survive and we were there when we could be to help each other out.

When on shift, a trainee who was only three months ahead of another trainee oversaw the shift. Each of us knew our role and recognised that there would be very little time to assist each other with tasks. We kept to the tasks ensuring that the work got done. Because it was a very small nursing school and the trainees were called on to carry most of the workload this support often

extended across the groups because we also depended on one another to teach each other when there was time. I remember on one of my early shifts a third-year trainee was in charge and she instructed me to disinfect with carbolic soap the bed of a patient who had just been discharged. I completed the procedure, which included cleaning the bed and locker and all the patient equipment used. After I had completed the task the third-year trainee came to check my work and informed me that my work was not completed. She explained in detail that it was not completed because it was required that after cleaning the patient call bell and cord that they must be place over the bed lamp, above the bed. This was the sign that the bed is ready for the next patient.

> *I never forgot that detail again.*
>
> *That evening, after the trainees on that ward had all gone off duty, I went down to the lounge with the other off duty nurses. Among them was the third-year trainee nurse who had been in-charge that day. In that company, in the nurses' home, I was Lesley and my junior trainee status was not of concern. We were all enjoying each other's company talking about our day and watching to see who was going out on a date that evening.*

Nicholson (1992, p. 30) in a 1992 study interviewed nurses who had trained in the 1960s and 1970s in hospital-based programs and found that they had gone through experiences like mine, quoting one participant's response:

> … students had a non- focused clinical learning experience learning tasks in the tutors' school and then being rostered on the wards to do the nursing work. The ward was a dual experience - complete the tasks allocated and if possible seek opportunities to learn. This was where it was expected that the student would build on their clinical learning related to what they had been taught in the tutor school. However, the registered nursing staff were focused on patient care and running the ward and had little time to teach students who were working with them on those wards... The Sisters on the ward had set rules for the students' work activities, task allocation was the approach to ensuring the 'jobs' related to running the ward and ultimately doing patient care. Each of the shifts had a set of tasks that need to be completed before a student was permitted to go off duty.

At the time, there was concern being expressed by trainee nurses from other organisations about the standard of tutor teaching in the courses. This view had been presented during the proceedings of the student nurses' conference that was held in 1964. This is later acknowledged by Nicholson (1992) who revealed that this concern was not only the province of the trainees but had come to include tutors of nursing courses. The issue that nurse educators lacked qualifications as teachers was also raised by the participants at a conference held in the Australian Capital Territory by the Canberra Continuing Education Centre following the release of the Goals in Nursing Education Report in 1975 (Duke 1975, p. 2). At this conference students also expressed their concern that they were treated as slave labour (Duke1975). 'Australian nurses at the present time are rarely adequately prepared to meet the total nursing needs of the patients entrusted to them' (Nicholson 1992, p. 30).

PRECEDENCE OF CLEANING OVER TALKING TO PATIENTS

From the beginning of my time on the wards I found myself very involved in the cleaning activities and realised quite early that it was going to be the focus of a lot of my working time for much of my training. Cleaning the ward furniture, beds, bedpans and bowls were as much a priority of the daily work of trainees as was cleaning the patient and doing general nursing procedures. As previously mentioned, Jayawardena, in a keynote address as a nurse leader when visiting Australia in 1961, had expressed concern about student nurses being used so extensively as members of hospital general labour. Jayawardena's (1961) understanding of the role of the nurse in Victoria in 1961 was like my 1964 experience when I first went onto the wards. In the beginning of my time on the wards none of the tasks expected of a junior trainee allowed much time to talk to patients other than to say '*hello*' and '*have a good day'*.

Patient meal time gave me some opportunity to talk to patients, albeit only for a short time. At meal times the senior sister on duty served up the meals onto the plates from a bain-marie that

was sent to the ward from the kitchen. We trainees then delivered the meals to the patients and assisted them if they needed to be fed. Unlike in more recent years, when patients are encouraged to get up and about very quickly, there were occasions when patients were discouraged from getting out of bed or even sitting up in bed. This was the case with patients who had suffered a Cerebral Vascular Accident. They were required to lie flat in bed for three weeks during which time nurses sponged them in bed and fed them while they were lying down. The idea was that the patient's heart should not have any strain. I was always perplexed, albeit silently, about putting these patients on a bed pan because of the stress of trying to open their bowels in such an odd position. However, I liked feeding the patients because it was another time when I could spend some time with and to talk to the patients. At other times I found ways to talk surreptitiously to patients, especially when I was dusting the furniture and window ledges around the patients' beds.

Having a quick friendly chat with a patient as I made a bed or cleaned their bedside locker was for me a foil for the rigidity of the rules and repetitive nature of the work. I also realised very early that patients were generally much happier if the nurses spent time talking to them, and I became convinced that such interaction impacted positively on patient welfare. Most patients were very encouraging, and they helped to make my life pleasant. However, I knew I needed to be cautious or I might hear:

'Haven't you got something to do Nurse?'!

This was a common admonition which I heard from the sisters when I was caught talking to patients while I was dusting.

Nicholson (1992), in a study about the experience of nursing students who had undertaken hospital-based education, explained that the students who attended the National Student Nursing

Conference held in Victoria in 1964 had expressed concern about the lack of communication skills being taught to nursing students. The students identified a need for a change in the curriculum that would expand their learning to include a focus on behavioural sciences including communication (Nicholson 1992). I did not attend that conference but would have supported their ideas. Nicholson (1992, p. 30) concluded from the participant responses to the research that junior trainees had a significant cleaning role and a limited role in direct patient care in the 1960s, and quoted one of the respondents as writing:

> Nursing tasks were not given priority according to any moral criteria and scrubbing of bedpans usually took precedence over patients' well-being. Caring and sensitivity towards patients' non-physical needs were often overlooked.

According to Nicholson (1992) the respondent attributed this to the demands made on the student to get tasks done in a timely manner. Most students, Nicholson (1992, p. 34) wrote, were '… cautioned against getting too involved and were taught to equate professionalism with aloofness from their patients.'

> *Even though I missed talking to and caring for patients I decided to take pride in what I did and went about doing the patient care that I could do at each stage of my training and doing the required cleaning with enthusiasm, no matter how mundane and repetitive.*

Every day after I had cleaned the pan room, including polishing the brass taps until the green Verdigris was no longer visible, I went on to refolding the linen that had come from the outside hospital laundry service, folding each piece correctly and placing it neatly into the ward linen cupboard. I then reported to the sister who was usually working at her desk in the sister's station. When I did this, it was quite likely that she would find another job for me to do such as cleaning and packing the equipment that had been used during the shift, including the used glass syringes and needles, the metal bowls, kidney dishes and the forceps used for wound dressings. These

tasks needed to be completed before I would be permitted to go off duty. As Russell (1990) explains, this was a time prior to disposable equipment being available in the 1960s. Any extra time was never used to talk to the patients.

> *At times when I was doing these tasks I felt a bit like an unseen automaton going about my business just getting the tasks done and making sure that I did not cause the more senior trainees and the sisters to find fault with me because it could mean further delay from completing my shift. Although I kept it to myself I was often very tired and annoyed by all the cleaning tasks that were required of me. It was frustrating also not to have much time with patients.*
>
> *Because there were so many cleaning tasks to do each day I would often drag myself off duty at 11 am when I was on a broken shift and should have completed my morning tasks by 10am. When this occurred, I knew that I would be returning to complete the work later that day. I also knew that I would often find myself going off duty late again that evening, leaving the ward at around 10pm knowing that I was required to be back by 6am. I was often sleep deprived and found it difficult to study when I was so sleepy.*

Years later there are still two smells that transport me back to that time - *Brasso* and methylated spirits. The *Brasso* was used to clean all the taps in the pan room and bath rooms and I also used large quantities of methylated spirits to clean the stainless-steel splash backs of the pan rooms, leaving them very shiny. Methylated spirits were in great demand in the hospital and it was also used as a patient back rub lotion.

There were some nurse leaders of that time who were very aware and concerned that when they were on the wards the trainee nurses were consumed with cleaning and were rarely available to do patient care. In an interview with the *Australian Women's Weekly* in March 1967 a visiting

nurse academic, Associate Professor Delores Little, made a statement about her concern that nurses did not see patients as individuals. According to Little (cited in Keavney 1967, p. 12) nurses were '… more focused on the ward than on patient care outcomes', and calling for '… the return of Humanity into Nursing' and making the point:

> Too often after a stay in hospital you hear patients complaining,
>
> 'I practically never saw a nurse. No one came near me. And hospital's too noisy. And the food's horrible. And nobody told me anything.'
>
> Nurses just don't have time to see the patient as an individual, with individual problems. They still have to occupy themselves with housework…

Many of our patients would spend long hours in bed and did not get to exercise very much. Their care was essentially undertaken by trainees who gave the required bed baths and pressure area care required to prevent pressure sores. One lady who I nursed for many months was among those who were bedbound. She was suffering from rheumatoid arthritis and lay immobilised during which time her joints began to contract until she could not hold anything in her fingers and her body was folded into a foetal position. I learnt years later that this could have been attributed to lack of exercise.

This lady was in a one bed private room and was only visited in the evenings for one hour by her husband after he came home from work and on weekends. Other than the time that her husband spent with her the only other people this woman saw were nurses. At the time when I did her hygiene and pressure area care I remember going into her room and doing the routines required for her care as quickly as possible, smiling as I went by, not pausing too long to talk. I realised that the lady did want me to stay and talk to her, but this didn't mean that I would stay long because the sister in charge of that ward always stressed to us that we should not spend too much time with patients. There were occasions when I spent longer than permitted and she sent one of the other nurses on duty to look for me.

I was quite disturbed one day when I went to do her care and found that she was crying. I didn't know how to help her, so I went to see the trainee who was the senior nurse on the shift that day. She told me to try to make her as comfortable as possible but that I wasn't to spend too much time with her because I had a lot of work to do. I did the pressure care and settled her into her bed and left the room telling her that we would be back to feed her later.

> *I realised that the lady was unhappy and asked my friend who came on duty for the afternoon shift to try to give the lady more attention if she had time that evening. When I went off duty that day I felt quite frustrated because I had not been able to really help this lady.*

PERFORMING REPETETIVE TASKS

Even though we were supposed to be supervised while performing the procedures for the first time on the wards there were times when there was no one to observe and I was sent to do the procedure without supervision. On those occasions I spent a lot of time poring over the notes that I would take on duty with me to make sure that I knew what to do. The most senior members of staff on some occasions were trainees who may have been only one school ahead of me, so I had to rely on them to also know what to do. It often felt like the blind leading the blind. This meant that I had difficulty in finding someone to sign off when I had practiced a task on a patient. On some shifts I worked alone while on others there were only other trainees and the only sister on duty was supervisor for the whole hospital on that shift. On these occasions I would report to the sister after completing the procedure and she would come to the ward to check what I had done, when she had time.

> *When I first thought about becoming a nurse I thought that the major focus would be bed making, washing patients, cleaning the ward and bedpans. On reflection I don't think that I had even thought about what other things I might*

learn besides some anatomy and physiology. Suddenly I was confronted with the idea that there would be a lot more to learn than I had ever expected or considered. Because of the way in which the Principal introduced the program I learnt quickly that day that the only people available to share my thoughts with were those having the same experience as me – the other three trainees in my group.

When I was first rostered onto any ward there were always some tasks that I was required to do for the first time. My first evening shift in the male surgical ward on my second ward rotation was no exception. While I was listening to the patient handover that afternoon I heard that there were two patients who were having surgery the next day and that both would need a surgical shave and one who was having abdominal surgery would also require an enema followed by a bowel washout. Sister told me at handover that as the junior on the shift it was my job to do the preoperative care. She also told me that after completing these tasks I was required to assist the other trainee, who oversaw the ward for the evening, to settle the patients for sleep. Having completed all these tasks and prior to going off duty it was necessary for me to ensure that the ward and pan room were clean and that I had cleaned and bagged all of the glass syringes that had been used during the shift, ready for autoclaving. When all that was done there were still the cleaning tasks allocated for that shift which needed to be completed.

When I went to talk to the senior trainee about the shaves and bowel care she must have realised that I was nervous, and she talked me through the tasks and gave me some tips. She told me that because she was so busy she wouldn’t be able to watch. I was relieved to hear that the local barber would be coming to the hospital to do the perineal shave and then my bubble burst because she told me that I would have to shave the man’s chest and give one of them an enema and bowel washout. She followed this with advice about using a safety razor because it was

important that, while ensuring that I removed all the hairs from the chest, I did not nick the patients skin. She explained that when the patient was in the operating theatre he would be under a very large and bright theatre light which would shine on the area to be operated on and the surgeon would be able to see any hairs that had been missed. These could be the cause of contamination of the surgical site, she explained.

At the time of doing this shave I felt like the ‘Sword of Damocles’ was hanging over me. I was thinking about what the senior trainee had told me and remembering the terrible stories that I had heard from other students about being rung in the ward by the operating theatre nurse advising that the surgeon was unhappy with the way in which the patient shave had been done. The trainee responsible had to report to the operating theatre to complete the shave. She had been required to get dressed in a theatre gown and, under the watchful eye of the surgeon who was complaining loudly about her incompetence, had removed the remaining hairs that were evident under the strong theatre light.

I was lucky that I didn’t have to suffer from this ignominy because when I was shaving that first man he picked up on my anxiety and helped me by explaining how I should do the shave using warm water and explained how to make lather with the soap. He was very encouraging, and I was more comfortable with this task in the future.

Even though we were not permitted to spend time in conversation with patients, there seemed to be other ways in which communication was accomplished, and they gave us more support than we were often able to give them.

After the shave was finished I went to find the senior trainee. She came and checked to see if I had completed it correctly. I was so relieved when she said that I had. She then reminded me that the patient also needed to have bowel preparation before surgery. I was to give the patient an enema

and then after he had opened his bowels I was to ensure that the bowel was completely clean by also giving him a bowel washout. The nurse reminded me that I must make sure that there are no faeces left in the bowel when I had finished these procedures. She went on to explain that if there were this could also incur the wrath of the surgeon and could result in cancellation of the surgery. What she said left me confused because I couldn't understand how I would be able to assess that there were no faeces in the bowel. It became more and more apparent that each time I was allocated to do a new activity it was common for the more senior trainee nurse who was working with me to give me the instructions followed by an announcement of the consequences of what would happen if I did not compete it to a satisfactory standard. There seemed to me that there was always some form of threat hanging over me if I didn't complete my tasks to the satisfaction of the doctors as well as the sisters.

On that first occasion I administered the enema and, after the patient returned from the toilet and told me that he had opened his bowels, I explained to him that I would be back later to do a bowel washout to make sure that his bowel was clean for the surgery. I left and collected the equipment that I would require on a trolley and returned to the patient room. I stepped behind the curtain of his cubicle and told him what I was going to do. I remember him saying '*do your best nurse*!' He had a smile on his face and seemed to be reassuring me rather than himself.

> *Over the years of my training it was the patients who were of most help when I was confronted with new procedures as in the case of the first surgical shave. They seemed to know that we trainees were under pressure to perform, probably because it was quite common for them to overhear what sister or the senior trainee nurse was instructing us to do. I was very grateful for a patient's patience and helpful comments on these occasions.*

While I was doing the bowel washout for the first time I struggled with all the various aspects of the task. When I started the bowel washout I had hoped that I would keep the bed, myself and the patient dry but unfortunately, I failed in the first attempt. Not only was the bed wet so were my shoes. In this procedure the task was to pass water into the bowel via the tubing and then to tip the water out again into a bucket that was on the floor beside the bed. This went on until the water returning from the bowel looked clear. There was no time restriction. I had been taught to place a special clip onto the tubing to restrict the flow of water as it passed into the bowel and to occlude the tube while passing fresh water from the jug along the tubing into the funnel. However, the clip failed. I then spent some time trying to restrict the water flow by kinking the tubing with the fingers of one hand while also holding the tubing in the anus in an attempt not to dislodge it and keeping the funnel upright while pouring the fresh water into the funnel with a jug. During the procedure I felt like I was all thumbs and no fingers while trying to teach myself how to kink the tubing that ran from the funnel and where it was entering the patient's bowel.

As had been the case on this occasion, I had learnt the principles of the procedure in the classroom, however the first time that I performed it was when I was on the wards as a junior trainee. I had not had a chance to practice previously and there was no one available to guide me through these procedures. However, once I had completed the procedure the trainee on duty with me would check to see if it was completed to their satisfaction. Most of my learning in this situation was very much hit and miss and checked for satisfactory completion by another student. Unfortunately, the patient was generally the one who was affected by my first fumbling attempts at a procedure.

Fortunately, because of the number of times that I carried out this treatment throughout my training, I became more confident and took the focus off myself and spent more time encouraging and supporting the patients.

Using the trainee to do the routine tasks, often unsupervised, on the wards and in the departments continued throughout my training. The bowel washout was to become an almost daily activity when I worked as the junior trainee on surgical wards and again in my third year when I was allocated to work for six weeks in the X-Ray department. When people came in for barium enemas they required a bowel washout in the morning prior to the afternoon X-Ray. Not only did I have to ensure that the bowel was empty but also that air was not captured in the bowel. I would quickly know if I had done a satisfactory job or not because I was the one standing in the dark by the X-Ray table next to the patient while wearing a lead apron over my uniform. I held the red rubber enema tubing with one hand and with the other held the nozzle located at the end of the tubing into the anus. I controlled the entry and flow of the barium into the bowel by pinching the tube with my thumb and fingers under the direction of the radiologist who was standing behind a lead screen. On these occasions, I felt like a technician rather than a nurse.

As a young fertile unmarried female, I had no education about the potential health implications of this activity for me. Only later in my career did I realise what the risks were and what the outcomes could have been.

> *I loved working in the X-Ray department because I worked Monday to Friday during the hours of 8 am to 5 pm and had the weekends off! However, even though I was working in a place where there was a great deal of technology to engage with, most of my daily activities were repetitive and mundane and after two and a half years as a trainee I wondered why this work required a nurse. It seemed that I had spent most of my time doing the same tasks day after day rather than learning something new.*

By the time that I finished my rotation in X-Ray I was working like an automaton. After two weeks in X-Ray I was restless. I spent most of my time in the set-up and clean-up room, however as I got closer to doing my final examinations I realised that I still had a lot to learn about what I was seeing in the X-Rays. I tried to finish my tasks quickly on some days so that I could take advantage of spending time with the technician learning how to read an X-Ray, realising that it would help me to improve my anatomical knowledge.

X-Ray was not the only non-ward environment in which I worked as a student. I also spent many months during my training working in the operating theatre. Working in major operating theatre required me to be very athletic. The first job of the day was to clean down all the theatre walls using a mop. They were very tall theatre walls and as it was a time of mindless work it was a good time for self-reflection. The next job was to help to set up the trolleys for the operation cases of the day. As I learnt more I was able to help with cases, firstly doing scouting (going for equipment and helping the scrub nurse), and then at last I was able to be the scrub nurse. I loved the role of scrub nurse even though long days standing meant a sore back and feet. There was order and predictability in the work. I also liked to be able to know which instrument would be used next without being asked. I was proud of that skill.

After the operations were completed the cleaning started all over again. Cleaning suction tubing was quite a performance to ensure that all the visible blood had been removed from the tubing, washing it with a pressure tap until there was no sign of blood. Then I would go outside to the driveway at the back of the hospital and swing it around my head to get the remaining water out of the opaque black or brown rubber tubing. It was the most fun I had all day. I could relax and was not required to be on my guard all the time when I did these types of activities. It was the same when it was my turn to go to the hospital laundry and wash the blood from the sheets and abdominal packs that had been used in the surgery. These were reusable items that could not

have any blood evident before they were sent to the laundry to be washed. It was a similar case for the bandages. Checking that the sewing needles were sharp and sharpening them if necessary, folding gauze swabs and rolling cotton wool into balls and cutting up combine dressing to be used as abdominal dressings were also included in the role of the student. If I worked in the evening I was required to complete the cleaning from the daytime and put all the sterilizing through the autoclave. This was a small hospital with few workers other than nurses. There were no porters or orderlies. The registered nurse in charge of the theatre had a reputation for being stern and strict so life went easily only if you knew the routine and followed the rules and understood the cleaning processes.

I did two rotations in operating theatre during my training. When I was on call for theatre during both my second and third-year experience I would be called out in the middle of the night if a patient needed surgery at that time. At those times at night, in a bleary state of tiredness after working a full shift and having had little sleep, I would have to set up the theatre for the procedure, work with the theatre sister, and then clean up after the theatre case had finished. No matter what time I finished my duties that night I was required to return to duty again the next day for the shift for which I was rostered. Sometimes I was lucky enough to be doing a late shift, which started at 1.30 pm, so I had a little sleep rather than the times when I needed to be back on duty by 7 am.

Working alone – primary carer and cleaner

It was the 2nd November 1964, 10.45 pm. I was headed towards the male public ward on my first night on night duty. I had been a trainee for two months having spent only one month on the wards following PTS.

As I walked down the corridor to the ward desk and passed the female intermediate ward my nose was assaulted by a sickly-sweet smell. There standing like sentinels outside the door of each room were vases of flowers. I thought about my friend who was going to be working on that ward that night and felt sorry for her. She would have a lot of work to do to put fresh clean water into all the vases because there was more than one vase of flowers outside each door. They had been placed outside the doors, not so much for convenience for the nurses doing the flowers, but because there was a view held at that time that if the flowers were left in the ward overnight they would take up too much of the patients' oxygen.

I walked on and entered the nurses' station of the combined male public general medical and surgical ward where I was going to be working on night duty for the next two months and was greeted by the second-year trainee who had worked that evening. I mentioned the flowers to her. She reminded me how lucky I was that I did not have any flowers to deal with on the male ward because the men did not receive flowers.

The evening nurse gave me the handover about the patients in the ward. Her information to me included the names, diagnosis, and condition and care regime of all the patients. When she had finished, she walked around the ward with me and pointed out the patients who would be requiring special treatment that night. I wrote some notes on a piece of paper for later reference. I felt anxious because I had sixteen sick men to care for, fourteen in the main ward and one patient in the room in the corridor near the sister's station (the office where the paper work was done), with another patient in the room at the end of the large ward room. This was the room where we often nursed dying or restless patients. It was only able to be accessed by walking through the large open ward past all the other patients.

Because I was new to night duty, the trainee reminded me of all the duties that a night nurse must complete in addition to the patient care. I was reminded to do hourly rounds to check on the patients, to total up the amount of fluids for the last twenty-four hours of each of the patients and include the total onto their fluid balance charts by twelve midnight, to transcribe the patient observations for the past twenty-four hours from the observations book onto the graphs that were in each of the patients' files, including the bowel information that was written in the bowel book. She also reminded me that I would need to rule up the exercise books that were on the desk and the set of cards (see Figure 3.19) that contained the information about the bathing and showering requirements of each patient for the next day. Each of the books was labeled differently: *Bowel Book; Bathing Book; Dressings and Procedures Book; Patient Food and Fluid Book*; and finally, the *Doctors Orders and Patient Observations Book.* My job was to rule columns on a clean double page in each book every night so that they could be used for the next 24 hours. The '*Doctors Orders and Patient Observations Book*', was set aside for the sister to use on the doctors' rounds and was where all the information for and from doctors about individual patients was located including Patient Name, Doctor's Name, Doctor's Orders and TPR, (Temperature, Pulse, Respirations including Blood Pressure). Among the books also was the *Daily Allocation Work Book* which contained a list of the cleaning that were to be completed by trainees on each shift every day throughout the year.

Figure 3.19: Second year night duty

Source: Hills 1964-7 Scrapbook.

Photo of me, in second year uniform, completing routine bookwork tasks on night duty.

Figure 3.19 shows me doing this bookwork on night duty. The trainee continued to tell me about all the duties that I had to complete before the day charge sister came on duty at 7.30 the next morning, including the administration of the 6.00 am medications and the four bed baths that had to be done between 5 am and 7 am. She showed me bottles of medications and the medication cups and some slips of paper with the patients' names on them. I was to use the slips of paper to label the medicine cups when I put out the 6 am medications later that night. I was told that if I did this early enough during the night it would mean that the 6 am medications would be ready on time in case the early morning was very busy.

I had been rostered to do my first rotation of night shift within three months of commencing my training and prior to the completion of my probation period. I was a first-year trainee not long out of PTS. When I was on night duty I was the only member of the staff on duty on the ward. A senior nurse or sister was rostered to oversee the hospital as supervisor on night duty.

The more that the evening shift nurse told me about what I was expected to have done by the time my night shift had finished, the more I struggled to see how I would get it all done, especially as I was still learning about the ward and where all the equipment was kept. Just when I thought that there couldn't be any more to do during the shift she reminded me that I had cleaning duties to do each night, and that night the drug refrigerator was due for cleaning.

After the evening nurse left the ward I took a torch and walked cautiously around the large ward to check on the patients. There was a small wall light situated near the floor at the end of the ward which at least gave the dark and gloomy room a small glow of life. Remembering to keep the torch pointed to the floor in an attempt not to wake the patients I crept around the ward and walked up to each bed and quietly looked at each of the patients. The man who was in the first bed on the left side of the ward had a fractured femur and was in a traction bed. There was a large wooden

Baulkin frame around his bed and his leg was elevated in a Thomas splint with a cord tied to the end with weights hanging over the end of the bed from the cord. I checked the weights because the evening nurse had told me to make sure that the weights were always hanging free so that the traction would work. I was instructed also to be careful when turning this patient in bed. This man would need pressure care during the night and was one of the bed baths I needed to complete in the morning. I knew that the only assistance I would get to move the patient would come from the nurse working in the ward next door, but we would need to negotiate our time so that we could assist each other with patients who required turning or to be put on a bed pan during the night. I decided that when I had finished my round of the patients I would go next door and talk to my fellow but more senior trainee Debra, who was on second year night duty, and ask her for help.

I continued to walk around the ward and checked the other patients who had undergone surgery that day and had intravenous therapy in place. I checked the fluid levels in the glass intravenous bottles and then checked the tubing and placed my nursing fob watch against the side wall of the drip set chamber of the intravenous line coming from the bottle. I counted the drops of fluid coming from the drip chamber, watching the second-hand move to the minute to ascertain the drip flow rate per minute and to make sure that it was running on time. Before the fluid in the flask was finished I would need to have the night supervisor check the new flask of intravenous fluids before I changed the emptied bottle. I was very cautious because I knew that I must not let the fluid run out because this would cause air to go into the patient's vein when the glass bottle and tubing were completely empty.

Satisfied that everything was in place I walked on to look in on the man who was in the room at the end of the ward. He had been admitted that day suffering from the delirium tremens (DTs). When the evening nurse and I had done the ward round she had told me that the night supervisor would be around later to help me give him an injection of Paraldehyde to limit his restlessness. He

had been given this injection earlier in the evening because he had been restless. As I went along to see this patient I continued to check on the patients who I had been told were incontinent.

That first night I got more than I was looking for and learnt a lesson about moving my hands around the bed of a patient in dark to see if it was wet and needed changing. My hand landed on a hard, round object that seemed to have a very soft substance in it and as I moved my hand further I encountered more of the soft substance. Realising what it was I removed the object and used my other hand to draw the curtains around the patient and carried the object and its contents out of the ward to the pan room. It turned out to be what I had expected - a glass ash tray that the patient had used in which to put the faeces that he had removed from his bowel with his fingers. He had been suffering from constipation. I cleaned the ash tray and my hands in the pan room, collected a bowl of warm water to give the patient a bed bath and collected the clean bed linen from the linen room and a dirty linen skip. Prior to walking back to the ward, I turned the corner to the next ward and told Debra what had happened and asked if she could come and help me in a few minutes after I started washing the patient. I then collected the equipment and returned to the patient's bed, went behind the curtains to wake him, and proceeded to remove the dirty linen and, after covering him with a sponge blanket, washed him and discarded the dirty linen into the dirty linen skip. It took some time washing the patient's hands and nails in the bowl of water to make them clean. It also took some time for me to clean my own hands and for a rather offensive odor to dissipate from the ward.

The patient was quite drowsy so was reasonably cooperative. Debra came to help me with the sheets and to roll the patient from side to side in the bed. She told me that she had contacted the night supervisor sister about the incident and let her know that she would be assisting me in the ward next door. While we were cleaning the patient, the sister came to the ward and checked behind the curtains where Debra and I were working. She told us that she would be sitting in the

ward office next door covering both our wards while Debra and I were completing the patient bed bath.

Debra mentioned that she thought that I had experienced a '*baptism of fire*' with so much happening on my first night of night duty. She also reminded me that even though I had given the man a bed bath I would still have four patient sponges to do in the morning because this man was not among those allocated to be sponged by night staff. Debra looked at the clock before she left and mentioned that she needed to get back to her ward before midnight because she had two patients for whom she had to make tea and toast because they were having an operation the next day and were required to fast from midnight. After she left I cleaned away the equipment and dirty linen and returned to the ward to find sister getting ready to give the man suffering the DTs another injection. She handed me a large glass syringe and ampoule of Paraldehyde, explaining that it would be good practice for me to give the injection because I had not given one previously. This was certainly a baptism of fire because Paraldehyde, apart from being a very painful injection, needed to be injected slowly. It also had a very pungent smell, which the ward and I reeked of for the rest of the night. As Nicholson (1992) identified, junior staff were often expected to carry out duties for which they had no training.

> *I became very conscious as that first night went on that I would have to become good at time management if I was going to get all the administrative and cleaning tasks done on time, as well as to complete the care needed by the patients, much of which was not always predictable. Making sure that I completed all the tasks on any shift, including on night duty, was important because if I left anything not done I would be called back to the ward, to complete them, even if I had already gone to bed and was asleep. One event*

> *that stands out for me is when I forgot to do an admission sponge on a patient who had been admitted during the night.*

All male and female patients admitted to the public wards were required to have an admission sponge no matter what time of day they arrived and no matter their diagnosis or their hygiene condition. I was on night duty as a third-year student and, as usual, alone. There had been more than one admission that night and by morning the ward was full and busy. I completed one admission sponge and the four required bed sponges for patients who were in the allocated beds. I gave my report and went off duty, had breakfast and went to bed. At about 9 am I was sound asleep when there was a knock at the door. One of my trainee friends had been sent to wake me up and to tell me to get back into uniform and go back to the ward. My friend told me that the charge sister of the ward in which I had worked the previous night wanted me to return to the ward to do the admission sponge on the new patient who I had admitted during the night. I got out of bed and, although I was drowsy, dressed in uniform and returned to the ward and reported to sister. She made a point of telling me that I needed to complete my duties before going off duty. I did the sponge and then returned to my bed sometime later realising that I had to be up again at 1.30 pm so that I could go to the compulsory lecture on Medical Nursing that was to be given by the physician at 2 pm.

The pressure is on: making mistakes

Administering medications safely was a continuing dilemma for me, particularly when I was on night duty, even after I had been taught the procedure in class. When a patient needed an injection of pain medication, as a trainee I was required to contact the night supervisor so that I could collect the dangerous drug cupboard keys from her. On one night, as was often the case, the supervisor was located elsewhere in the hospital, so after I found her I collected the keys and returned to the ward. I removed the box of ampoules of the medication from the drug cupboard

and placed it in a kidney dish along with a glass syringe and needle and took them and the drug book back to the supervisor. She removed the ampoules from the box and counted out the remaining ampoules and countersigned the Dangerous Drugs Book. I then drew up the injection in front of her and placed the filled syringe and empty ampoule in the kidney dish and returned to the ward with the medications and drug book. I then locked the remaining medications in the dangerous drug cupboard. When I returned to the ward with the medications it was the beginning of the early morning routine when I had to begin all my tasks. They were to be completed prior to the ward charge sister coming on duty to take handover at 7.30 am.

I administered the injection of pain medication to the wrong person. I realised what I was doing almost immediately and stopping quickly. I contacted the supervisor to report the incident to her. I was shaking when I rang her because I was distressed that I had made this error and that I would be considered to be a bad nurse. She was immediately angry and told me that I was lucky because the patient should have no ill effect from the drug but that I had made a terrible error. She instructed me to write it up in the patient notes and to get the injection out for the correct patient. She then came to the ward and admonished me again for my mistake and watched as I gave the correct patient the injection and then contacted the doctor and Matron. As she left the ward she told me to report to Matron before I went off duty. The charge sister of the ward heard my report that morning and was quick to say that the event would teach me to pay better attention to my work and reminded me to go and see Matron. I finished handover and competed my cleaning up after the shift, thinking all the time that I would be dismissed. Fortunately, the medication did not have any undue effect on the patient. Notwithstanding that, I learnt a salutary lesson on that day and the impact of this event remains with me today. When I have been required to administer any medication by injection I find myself double checking even when others check the medications and go to the bedside with me, which is now a requirement.

When I went to see the Matron as I went off duty I was feeling churned up and inadequate. I had already chastised myself and kept asking myself why I had made that terrible error. I felt guilty and contrite. Matron reminded me that I had been lucky that the patient didn't die. She reinforced that I should be paying better attention to my work. Just before I left the room she said something to the effect that it wasn't necessary to tell my mother about this incident. After talking to Matron, I left the office very perplexed. I could not even guess what she had meant about my mother. I always thought that she made this comment because she didn't want me to look bad in the eyes of my mother because she was also a nurse. On reflection I wonder if there was also some concern about the unsafe practice involved in this hospital procedure.

Doctors needs take priority over patient needs

Night duty was the time when I learnt many new lessons, especially how to cope in an unpredictable environment when I was working alone. Another event stands out clearly even now from the time when I was on third-year night duty in the female surgical ward.

On this night, I was walking down the ward corridor to answer a patient's call bell that had been rung in one of the private rooms. I looked along the gloomy corridor and saw one of the honorary general practitioners (residents were not employed in this hospital) come out of the patient's room. He called out to me to come and help him and to bring a dressing trolley with me. I was astonished as the doctor was standing there in his dressing gown in the middle of the night, and I had not even known he was on the ward. He had arrived in the hospital to look at the patient's wound. The doctor had operated on her some days before. She had an abdominal wound. I had been told at handover that the wound suture line had broken down and was gaping and that the doctor was thinking about resewing the suture line.

I hurriedly collected the equipment and pushed the dressing trolley to the patient's room. I looked into the patient's bedroom and saw that the patient was wide awake and that the bed linen was pulled down to the end of the bed, and that she looked very distressed and was holding her hands tightly over her chest. I noticed that there was no covering on the wound. The dressing had been removed and was lying on the bed covers. The doctor took a combine dressing from the trolley and put it on the wound. I could see something pulsating in the wound before he covered it. He instructed me to clean the patient up and left the ward without talking to me or the patient. I found out later that he had also not written up his visit in the patient record.

As I re-dressed the wound I talked to the lady. I was very concerned for the patient because she had been woken in the middle of the night at what seemed to me to be at the whim of the doctor and had not been able to take any control of the situation. She had a very smelly gaping wound and had not been given any pain relief before the doctor had removed the dressing and had started to prod and probe around the wound.

I took a little time with this lady while I cleaned her up and settled her down. She told me about being worried about what she had seen because the wound looked bad and was smelly. She also wondered why the doctor would come to the hospital in his dressing gown. She told me that she did not feel that she could ask the doctor about what was going to happen to her.

Although I had not felt able to defend the patient against the doctor's invasion I thought that the night supervisor might be able to help me with the situation. I rang her and told her what had happened. She told me that there was nothing that she could do about the doctor's behaviour, to just clean up the patient and settle her down. Over the years this event became indelibly imprinted on my mind, primarily because I had not been able to advocate on her behalf for a more caring approach.

I recognised again that night, as I had many times before, that I should spend some time talking to my patients, even though this was not encouraged. I was especially concerned for this woman and had hoped that it would help her with her distress. It was not the first time I realised that I could help a patient by talking to them.

I had an opportunity to put this into place on another night when I was nursing a lady who had shingles and was having difficulty sleeping. After realising that she needed some special attention I went to the neighbouring ward to explain what was happening and to ask the nurse to keep an eye on my ward and to let me know if any bells rang so that I could spend some time in the bathroom with the patient. As was a very usual team work approach between us my colleague agreed to help, and I was able to spend some time supporting this distressed patient. I ran her a warm bath and made her a cup of tea and, having checked initially that the rest of the patients did not need anything, spent some time talking to her while she bathed. Although it was not a miracle cure I realised that she was much more settled when she went back to bed and I was hopeful that I had contributed to that. It was a good feeling to realise that there were times in which I could make a difference. If I completed my work on time I could spend some time with the patients.

On night duty when I was not constantly under the watchful eye of the charge sister proved to be a good time to spend time with unsettled patients. A cup of tea and a talk were exceptional nursing practice I thought then.

When I was talking to my friends after the incident of the doctor's unexpected visit, during one of our many toast and tea get-together's in the nurses' home lounge-room, I recounted my experience. At that time, as we had often previously, we talked about how inadequate we felt at not being able to defend

our patients at times like these, even though we had been taught the importance of supporting them in PTS.

I was particularly bewildered by this because of what we had learnt in class about how to support our patients in accordance with the teachings in our text book by Doherty, Sirl and Ring (1963, p. 4) headed *Advice to Student Nurses*, in which it was stated:

> The patient comes to you in simple faith-offer him sympathy, respect his confidence, and inspire him with courage, hope and a feeling of security. From the moment of his arrival, to the time of his departure, show by example that each and all are co-operating for the sole purpose of curing his illness, alleviating his suffering, and ministering to his needs and his comfort. Let him feel that you are assisting him to return to his place in the community as quickly as possible.

CHANGING TECHNOLOGY - NEW NURSING PRACTICES EMERGING

Most of my days of work in first, second and third year had similarity and predictablity, which meant that they were mostly concerned with cleaning patients, the ward environment and equipment. The work was essentially mundane and repetitive. At the time that I was studying for finals examinations I was privy to several events that highlighted for me the potential for change to patient care practices that may result in a different focus for nursing practice. A few significant events stand out for me - the introduction of a new medication, new technology, and a speech made by a registered nurse who had worked in Vietnam as a civilian nurse during the Vietnam War.

One evening I was a third-year trainee and was the senior nurse on the female public ward for that shift. Early in the evening the evening supervisor had instructed me to go to the casualty department because she was busy with another patient. She explained that a local general practitioner (GP) was sending in a very sick patient. The patient was a woman who was suffering from an acute incidence of congestive cardiac failure, arriving by ambulance at the same time as the GP arrived. On arrival she was breathing noisily, and I thought that the gurgling sound that she

was making could mean that she was affected by a fluid build-up in the lungs, a condition that I had previously heard about in other patients.

When the doctor arrived, he handed me an ampoule of liquid for injection that he had carried into the hospital in his pocket. What followed next seemed to be (in my opinion) a medical miracle. The fluid in the ampoule was a diuretic called Furosemide, which I had not seen or heard of before. It was a non-mercurial diuretic and up until this time all diuretics used in the hospital had been mercury based. I had never seen injections of mercury-based diuretics result in what I saw occur after the doctor administered the Furosemide intravenously to this patient.

Prior to administering the Furosemide, the doctor told me to set up a procedure trolley for patient catheterisation. I then catheterised the patient and inserted a wooden spigot into the end of the catheter to prevent urine pouring from it into her bed. He then took some time to talk to the patient to try to settle her and then injected the diuretic slowly intravenously into her arm. The doctor then instructed me to get a kidney dish and to take the spigot out of the catheter and to allow the urine to flow into the kidney dish. While that happened, I was to find a catheter bag to attach to the end of the catheter so that the urine could flow into it. I was surprised by this request because I had not used a catheter bag often, other than to attach one to a uri-dome being worn by an incontinent man. I found a bag and attached it to the end of the catheter and saw that the urine continued to flow into the bag. The woman's condition changed dramatically in what I thought was a very short time, and more quickly than I had experienced in my short nursing career. Her breathing started to improve slightly. I had previously nursed people who seemed to get sicker and sicker when they were suffering fluid build-up and the doctors often talked about them being at risk of drowning in their own fluids.

By the time that the doctor had decided to admit the woman to the ward she was having oxygen administered via nasal catheter and her breathing had settled considerably. I pushed her to the ward on the patient trolley and then assisted her to move into a bed and sat her upright in Fowlers position against the pillows. She slowly settled down and she was breathing much more quietly than when she had first arrived in casualty.

> *That night I had learnt that there were new practices and medications becoming available which would help to improve patients' experiences. I couldn't wait to tell the other trainees in my group about what I had been a part of and seen.*

At about this time there had been several new pieces of equipment arriving in the hospital and being set up for use in the operating theatre. I had been introduced to some of them during my third-year rotation in operating theatres. Strahan (1991, p. 140) elaborates:

> Extensive building developments and the establishment of ancillary services necessitated a continual modernisation of equipment, with the increasing financial burden that such change involved. In 1964 the iron lung respirator, presented by Lord Nuffield thirty years before, was retired. Overhead screens, mobile x-ray plants, theatre lights and an anaesthetic machine were purchased. Sophisticated appliances such as defibrillators and cardiac monitors, expected by the community to be available in even the smallest hospital, were installed.

This new equipment was not available in the wards so, consequently, the oxygen cylinder and mobile patient sucker were probably the most important piece of equipment available on the ward of the hospital. Although I was aware of the new equipment in the operating theatre I was not aware that this and other new specialised equipment such as respirators were being introduced into the wards of some hospitals and were being used to support and sustain life at the bedside.

On another afternoon, I had just come on duty as the senior nurse on the female intermediate ward for the evening. I had been reflecting that I had been enjoying working in the operating

theatre and was thinking that it would be a good place to work when I graduated. I had loved working in the operating theatre on both my junior rotation as a second-year and my senior rotation as a third-year trainee. I had spent twelve weeks of my training learning about the instruments required to be set up for specific operations but knew little about the body other than what I could glean if I was standing close to the surgeon. Such opportunities to learn from the surgeon did not happen often because I was generally busy working as a scrub nurse, ensuring that the nurse who was assisting the surgeon had all the equipment that was required.

> *Even though I did not know the detailed anatomy I was looking at during the surgical procedure I did not dwell on this. I was happy that I understood what I had to do because it was routine. I knew I was capable of cleaning and following orders and worked well as a member of this well-oiled team, smiling as I went about my duties. I liked knowing that I was learning the names of the instruments that were being used in the surgery. I felt like I was part of the team. I was also aware that this knowledge would be invaluable to me in the surgical instrument vive voce that I would be required to do during my final examinations.*
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> *My commitment to the operating theatre was rewarded when I was awarded the prize for the best theatre nurse in my year at my graduation ceremony.*

Over time late in my trainee nurse days I became more and more concerned about my knowledge and capacity to be skilled and knowledgeable after graduation. Two events that occurred in 1967 when I was completing my third year as a student nurse reinforced this view for me. One was a special nurse seminar that Matron took all interested students to in Melbourne one evening to hear a talk by a registered nurse who had trained at the Alfred Hospital in Melbourne and had spent some time in Vietnam working in a civilian hospital. It was then that I also learnt that civilian nurses had first gone to Vietnam from the Royal Melbourne Hospital in 1964 to work in that war-

torn country. The registered nurse told the audience about her experiences working with very little equipment and medications in very dangerous circumstances, trying to look after the civilian population of Long Xuyen in South Vietnam. I was overawed by this nurse who told us how she and her colleagues had to be able to draw on all their knowledge and skill and abilities to improvise when they were working in this ill-equipped hospital that also did not have running water. I had never considered that Australian nurses were working in these kinds of conditions or that these conditions existed in the world.

> *My memory of what she told us stayed with me for some time and the more I thought about what she had told us the more I became concerned at my ability to function as a registered nurse. I thought that I had somehow been isolated from the real world. Her story played on my mind to such an extent that I thought I was not ready to be a nurse outside of the hospital where I had trained. This was of real concern to me because I was intending to work in the hospital in the town where my mother and family now lived in NSW.*

That evening, following my musings about missing the operating theatre, I learnt that there were more possibilities for my future that would include the use of the new technology to which I had been exposed. I received a telephone call from the charge sister of the casualty department who told me that one of the doctors was bringing a new patient to the ward for admission. She explained that the doctor wanted the patient admitted to the single ward and that one of the sisters from the operating theatre would be her specialling nurse. The woman had been diagnosed with gas gangrene of the leg and because she had needed to be intubated her breathing was being supported on the Boyles anaesthetic machine that was generally kept in the minor operating theatre. Sister also informed me that the doctor would be staying with the patient until he was

satisfied that her condition had stabilised. This could mean he might be there all night. I was surprised because it was unusual for a doctor to stay overnight in the hospital.

I was equally surprised that they would be bringing the Boyles machine into the ward and was relieved that care of this patient would not be my responsibility. I worked with the other trainee on duty that evening, and we prepared the room - setting up the bed and putting out the equipment that we knew was required for an unconscious patient, including the mobile suction equipment, and awaited the admission.

The doctor wheeled the patient trolley along the corridor with the sister following close by pushing the Boyles machine. The casualty charge sister was walking along beside the patient trolley because she was making sure that the tubing remained attached to the patient's endotracheal tube. The doctor asked us to remove the bed from the room because he did not want to disturb the patient tubing and therefore he would treat her on the patient transportation trolley. This was another new experience and was contrary to the usual rules of patient care in the wards. We moved the bed into the corridor out of the way so that there was room for the extra equipment in the small patient room. Even with the use of this approach the patient unfortunately died.

I had never seen a patient nursed in the ward while having their respirations supported by machine. Later the doctor, who was the GP who did anaesthetics and with whom I had worked in the operating theatre, explained that he would have preferred that she had been attached to a respirator but, because we did not have one in the ward, the Boyles machine was a good substitute.

The Boyles machine's main use was to support patients who were having an anaesthetic in the operating theatre. This and the new mobile X-ray machine were the largest and most important

pieces of equipment held in the hospital throughout my training. I asked the doctor about respirators and, after he had explained their use, he told me about the new wards known as Intensive Care Units that were being established in some of the major metropolitan hospitals. He also explained that there were courses being run in these hospitals.

> *I was really interested in learning more about the new technology that the doctor was talking about and how things might improve for patients. With this new information and from what I had learnt at the seminar about the civilian nurses in Vietnam I realised that I needed to look for education to do after graduation, so I asked him where I could find out about Intensive Care courses. He told me that some hospitals had recently commenced running these courses for registered nurses. I listen with interest, recognising that this might be the opportunity I needed to learn about the new practices later that year. I applied to do an Intensive Care course of six months at a hospital in metropolitan Melbourne. I was accepted for the course that was to commence in June 1968.*
>
> *My experience of these changes caused me to begin to realise that my training was not adequate to practice effectively in the new era that seemed to be occurring.*

Russell (1990, pp. 140-50) considered that the changes that were occurring during the period of my training added complexity to the role of the nurse at that time, stating:

> Throughout the 1960s and 1970s the role of the nurse became increasingly complex as a result of rapid social and technological changes. As science and medical technology developed, doctors became more involved with the complex problems of diagnosis and treatment, and nurses began to assume greater responsibility for many of the new technical procedures. As hospitals adopted new technology, nurses became more and more concerned with machines, equipment and other such devices.

GRADUATION – SISTER HILLS

'*Come in Sister Hills'*, I heard, as Matron opened the door to her office. She was smiling as she greeted me, and I walked cautiously into the room. I was not wary about meeting Matron on this important day - although I was worried that my new sister's veil might fall off my head. It was three years and one month since I had walked into Matron's office on that auspicious first day of my training to become the sister who I had officially become on this day.

On my first day as a trainee I had been cautious about the cap on my head which I eventually mastered and now the veil was the only thing on my mind. I looked at Matron and remembered that she had been wearing a veil very confidently on the first day on which I met her, but now she was wearing a sister's frilly edged cap. She had taken to wearing this during the years of my training because the veil was starting to be phased out in some nursing organisations. I had heard that there was a plan to use caps for sisters rather than veils and I was very opposed to this happening because I had spent that last three years visualising myself in the veil and being called 'S*ister*'. I believed that I had worked hard for this recognition.

> *Earlier that morning, as I had dressed in my nursing sister's uniform for the first time, I had reflected on what I had achieved over the past three years since walking through the hospital doors with my father for the first time. I had spent many hours learning in the classroom and working on the wards doing the tasks that had been allocated to me and had passed all the examinations and all the required clinical hours including making up the time that I had spent on sick leave after having my appendix removed while I was in second year. I had progressed from the first-year cap to the second-year cap and finally the third-year cap.*

In the evening prior to going to Matron’s office on 30th September 1967 I had prepared a sister’s veil and had put the last third-year cap I had used into the laundry bag. The performance of starching the veil so that it would be able to be folded and hold the kite shape as expected of the Victorian trained nurse of the day was extraordinary. I used a kitchen sponge to spread the starch as a thick paste onto the veil as it lay on the ironing board then, using a damp cloth placed over the veil. I ironed it, shaping it as I went. The first time I had seen this ritual was when I was a child watching my mother iron her veil each night before she went on night duty. I especially recalled the clicking sound it made when she pealed it carefully off the ironing board. It was a ritual that I had looked forward to during my training days. It was quite a letdown to find how difficult it was to keep that kite on my head, even when using a piece of tissue paper pinned onto the crown of my head so that I could put a hat pin through the veil to attach it to the tissue. Photos of me at that time, including the graduation photograph (Figure 3.20) at the end of this chapter, demonstrate that I didn’t have the knack of making myself look like the regal sister I had seen myself as when I was a child.

While I was preparing for work that morning I thought about my many experiences as a trainee. I recollected some of the patients who I had met and the nurses I had worked with. I was sad that I was the last of my group to be putting on the veil because I had to make up for that one month’s sick leave. This was a requirement ensuring that I had completed three years of training in total. All the others who had been in my group had left the hospital to take on other roles. Annette had returned to the country town where she had grown up and was now working in the local hospital. Barbara had returned to Tasmania and had enrolled to do midwifery training there. Jenny had not completed her training because she had become pregnant in second year and had since married and had the baby. She had resigned from the course because trainees were not allowed to marry, let alone to have a baby while training. My saddest memory was the death of my father in 1965.

Mum and I had talked the previous night on the telephone about this special day when I would wear a veil for the first time, and Mum mentioned how proud Dad would have been. Although these feelings of sadness at loss of friends and my Dad were on my mind I was also very excited to be getting ready to be the sister I had aspired to be for so long. I put on the veil and pinned it to my head. It moved around and felt unstable, so I attached more bobby pins to try to anchor it in place. As I left the nurses' home I looked around at my room to make sure that I had not missed anything that should be packed in the suitcase which I would retrieve that evening after my shift was finished. I had packed up my belongings the previous night because I was going to move to a room in the sisters' home in the house two streets away where I had originally attended PTS classes.

When I entered her office, Matron said '*Congratulations Sister Hills*, *it is always a good feeling to see our students graduate. Good luck'*. After meeting with Matron in her office I proudly walked down the corridor and onto the ward and reported to the sister in charge of the ward. The patients who I had been caring for as a student on the day before my official veiling clapped loudly as I walked into the ward and the sister came forward and congratulated me. I walked around with a big smile on my face trying hard to maintain my dignity. But that was not to be. The first time that I walked behind the curtain to do a patient sponge the veil promptly came off and fell to the floor! I soon realised that the veil had no purpose for the working nurse other than to be decorative, and only when not doing patient care! I thought to myself maybe that is why so many trained nurses only did work that did not require them do go behind the screens too often.

Similarly, I started to rethink all the rules of behaviour which seemed to define me as a nurse and to question my own nursing knowledge. Even though I did have some concerns about my knowledge of the science that underpinned practice, I also realised that I was not prepared to follow the rules and routines as blindly as I had in the past. I was now a sister and I was growing up. When I commenced my training, I was only seventeen and a very malleable young country girl. Since then I had studied, learnt, and grown up and graduated as a trained nurse at twenty years of age. At that time, I was looking forward to expanding my knowledge by doing the Intensive Care course in the following year.

Figure 3.20: Graduation photograph

Source: Hills 1964-7 Scrapbook. Graduation at Town Hall 4th October 1967. (author is second from the right in the front row).

CONCLUSION

In this chapter, the first of the autoethnographic chapters, I have shared stories remembered from the first three years of my nursing journey - those years of my training to become a registered nurse in a hospital-based program. During my time as a student nurse I was learning not only about how to be a nurse but also about how to become a member of the nursing culture. This involved learning the rules and regulations about how to behave as a nurse. I described the impact that the various experiences had on me as I tried to learn how to act in the nursing world. I have also interspersed information about nursing and the role of nurse educators at that time.

CHAPTER FOUR - GROUNDSWELL FOR CHANGE

INTRODUCTION

This chapter represents a bridge between Chapters Three and Five in which I have shared aspects of my registered nursing education experience during the years 1964 to 1994. It highlights the work being undertaken by committed nursing professionals concerned with the level and quality of nursing education, especially that which became evident during the 1970s. At the centre of discussions at this time was the position that there was an increasing need for new knowledge and a change of direction in the way in which, and where, nursing students were being taught.

One aspect of undertaking this autoethnography included using literature and documents to gain information that would support my personal story. As well as drawing on journals and books from the published nursing literature I have also extensively used archival material. In this thesis a decision was made not to approach other people to support my story however the information gained through the documents obtained in the archives has resulted in new voices being identified. They have strengthened the story of nursing education.

To obtain the archival material I first explored my personal archive that I had kept throughout my nursing career to identify relevant documents. Among the material that I had collected was a scrapbook which contained800 documents, curriculum information, examination results, photographs and other artefacts that I had kept during my training days. This was an excellent source of information, some of which I used in Chapter Three 'Enculturation' and Chapter Five 'Transformation'. In 2010 I visited the hospital where I had undertaken my education and was able to obtain other records of my training days. These have expanded on the information used in Chapter Three, and support of the story of my training.

My next exploration of archival material occurred at the time of my visits to the National Library in Canberra and the Public Record Office of Victoria in Melbourne[1]. At the time of my visit to Canberra I was fortunate to be accompanied by the person who had been instrumental in having the records from the Royal College of Nursing and the National Florence Nightingale Committee (Australia) 1946-1993 located there. It was important for me to have this support because the records were held in several boxes in which the documents were not catalogued. This opened my eyes to the uniqueness of what was held there because these records are difficult to access.

The Public Records Office of Victoria was equally revealing because, as I looked though the government files that had been stored there, I found that they held letters and documents that showed the interaction of members of nursing organisations and members of government discussing their various perspectives of nursing education at a time prior to, during and immediately following, my nursing training. Although there is some evidence in the published literature about the events depicted in the correspondence held in both facilities I became aware that I was seeing documents that may not have been seen since they were originally filed. In recognition of the value of these artefacts I have included copies of some of the original documents from these archives as Appendices to this thesis.

From these documents it became evident to me that prior to the transition of pre-registration nursing education to the higher education sector there was concern held by nurses who held influential leadership roles about the adequacy of the way in which nurses were being taught in hospital-based programs during the years of my training. Parkes (1984, p. 177) was one nurse who

[1] These documents are in the Victorian Archives in the following files; VPNS 6345/8/0 Unit 263 File 1458 June 1972 and VPNS 6345 Unit 435 File 1201 Part 1 and others are in records held in the National Library ID1347424.

acknowledged that nurse leaders were concerned about contemporary nursing education when writing, 'For some time now nursing leaders in Australia and elsewhere have been looking critically at traditional patterns of nursing education and practice.'

These documents have revealed the action that nurse leaders and some nursing organisations took to change the education of nurses for registration, particularly in Victoria where I trained, and later more broadly Australia-wide. In this chapter I open with an explanation of the work of members of the profession, mainly in Victoria, as they lobbied for a change in the way in which nurses were being educated in the years surrounding and immediately following my graduation as a registered nurse.

TECHNOLOGY WAS ADDING COMPLEXITY TO NURSING

In the early years following my graduation nurse leaders were acknowledging the impact that increasing technological change was having on nurses' work because it was adding complexity to their already very busy working day. The argument of complexity of nursing was being used as leverage for a change in the contemporary approach to the way in which nurses were educated. Initially members of the nursing profession were seeking a change in the syllabus and classroom hours of students. This position was evident in the Report of the Committee of Enquiry into Nursing in Victoria 1965 in which the RVCN had stated that '… not only is medical and scientific knowledge increasing rapidly … the observation and therapeutic measures carried out by the nurse are becoming more complex' (RVCN 1970, p. 12). However, because the experience of complexity was mostly anecdotal there was little opportunity to support the argument until later in the 1970s. McCoppin and Gardner (1994, p. 89), when writing about the impact of the technological advances on nursing work, drew on the study undertaken by Sidney Sax in 1990, explained that:

> Sax (1990 p. 81-89) wrote extensively about the health care system that existed in the early 1970s where he discussed the impact that was felt by the health care system with the increasing use of technology on health care delivery and on the way in which nurses worked and how they were employed.

ARGUING FOR AN IMPROVEMENT OF THE CURRICULUM

Coinciding with the argument about the increasing complexity in nursing the Victorian nurse educators were arguing that '... an improved curriculum is urgent' (Whitfield, 1969 p. 1). I had not previously been aware of the involvement of our nurse leaders in trying to implement a change in the way in which nurses were educated for registration. It was a surprise for me to realise when I found the letters in the Public Record Office of Victoria that Whitfield, who was the Principal of the hospital where I had trained, was an active participant. Whitfield, in her position as Chairman of the Nurse Educators Section of the RVCN, wrote to the Victorian Minister for Health, The Honourable Vance Dickie MLC, on 8th September 1969. Whitfield drew the Minister's attention to the concern of her members that the results of the enquiry into basic nursing education, which had been set up more than two years previously, had not been released. Whitfield (1969, p. 1) (see Appendix 4) asked that they be released urgently, stating:

> We consider the whole question of an improved curriculum is urgent. Each year medical techniques and knowledge become more complex and consequently the demand for skilled, intelligent nursing care increases. Our endeavours to provide suitable personnel, capable of fulfilling this demand is hampered by a curriculum outdated by over 30 years.

Whitfield (1969, p. 1) also referred to a letter written by a medical practitioner Dr Liddell, to the editor of *Melbourne Sun,* which had been published on 3rd July 1969. Liddell (1969) proposed raising the academic standard of the course and placing emphasis on bedside teaching. Whitfield (1969, p. 1) commented:

> We believe that this can only be done by implementation of the proposed curriculum. Whatever teaching is carried out at the bedside must be educationally planned, then implemented and supervised by suitably prepared registered nurses. Unless preparation is made now for the future, the standard of patient care will deteriorate.

By 1969 I had been a registered nurse for two years and coincidentally, at that time, RVCN was awaiting the outcomes of the Enquiry into Nursing.

Nearly a year later, when the report was still not forthcoming, the Nurse Education Section of RVCN sought to make a deputation to The Right Honorable Sir Henry Bolte, Premier of Victoria. Evans (1970, p. 1) on behalf of RVCN wrote to the Premier on 26th March 1970 'We wish to discuss general nursing conditions and, in particular, the modernisation of the existing training curriculum that is based on the curriculum laid down in 1928.' (see Appendix 5)

On behalf of RVCN Connor wrote a submission to the Victorian Minister for Health on 22nd August 1969 in support of the deputation. The following is an excerpt taken from that submission (Connor 1969, p. 2), (see Appendix 6):

> The Royal Victorian College of Nursing, as the professional nurses' association, is vitally concerned with the standards of nursing care available to the community and with the adequacy of education available for the preparation of nurses.
>
> It is believed that the situation at present is crucial and that the pressing problems associated with the provision of safe nursing care should be brought to the notice of the Minister.
>
> The provision of safe patient care is dependent upon having adequate numbers of properly prepared nurses of all categories, including highly qualified and experienced supervisory positions.
>
> The ever increasing complexity of medical treatment results in continually increasing demands being made upon the time, efforts and skill of nurses.
>
> Two major area of concern are:
>
> 1) The inadequate number of trained nurses employed in hospitals for the provision of safe patient care.
>
> 2) The unsatisfactory education programme for the provision of safe nursing care in the future.

The submission by RVCN was made at a time at least ten years prior to when quality assurance programs were being officially introduced into the health care sector of Australia (Connor 1969). At that time RVCN was making an argument based on what they knew anecdotally was being experienced in the health care system. This was because there were limited resources available for

the collection of data that would have been useful to support the College's argument (Connor 1969).

Connor, (1969, p. 6) on behalf of RVCN, reiterated the concerns that the current situation was believed to be impacting on the quality and supply of nurses, finishing by observing that:

> It is believed that an improved basic nursing education programme will result in the following:
>
> - Stimulation of recruitment to the profession initially and back to it
> - Better prepared, more skilful personnel
> - Reduced wastage from nursing.

The Committee eventually brought down its report in August 1970. The recommendations included an increase in classroom hours and information relating to students being given opportunities to work in venues such as community health, domiciliary nursing and psychiatric health. This experience and the related travel were to be arranged by the hospitals that employed the students (RVCN 1970).

Although they were pleased to see the release of the enquiry RVCN still had some misgivings and made a further submission to the Minister (RVCN 1970, p. 11).

> The Royal Victorian College of Nursing is deeply concerned with the provision of high quality patient care for the community and it is believed that this can only be achieved when the major part of the nursing service is provided by the general trained nurse.
>
> The Royal Victorian College of Nursing believes that the standard of nursing care provided for the community by the general trained nurse is largely dependent upon the quality of nursing education she receives.

The enquiry recommended a 1200-hour curriculum but RVCN (1970, p. 12) had requested a 1600-hour curriculum which represented a significant change from the 800-000 hours of my training. In the early 1970s some states changed the classroom hours of hospital-based pre-registration nursing programs. By this time '... the curriculum in South Australia had also been increased to 1000 hours' (Durdin 1991, p. 191). In 1976 the New South Wales Nurses Registration Board

released a new syllabus of 1000 hours of theory. The New South Wales syllabus included new subjects that were also reflected in the new college programs of South Australia, Western Australia and Victoria, such as behavioural sciences and social sciences. The clinical experience prescribed in New South Wales at that time included the requirement for hospital-based students to spend time in psychiatry, midwifery and community health (Russell 1990).

The RVCN were very strong in their disagreement with the recommendation for a 1200-hour curriculum for the hospital-based programs (RVCN 1970, p. 12), responding:

> The "practicalities" relating to the adoption of the above recommendation appear to relate to, Patient Care Staffing, Recruitment and Wastage, Physical Facilities and Finance. However student learning was not a focus of this decision.
>
> The proposed curriculum (by the profession) was designed to cover a certain amount of theoretical content in 1600 hours and to provide a carefully selected clinical experience in order to prepare the nurse to be able to give the kind of patient care to which the community is entitled.

RVCN continued:

> As the aim of the curriculum is to prepare a nurse to provide comprehensive nursing care for all conditions common in the community it is considered essential to specify the minimum time the nurse must spend gaining such clinical experience in order to ensure that all nurses are able to fulfil the functions stated in the purpose of the curriculum.

The new curriculum document was approved by the Minister in 1971 and launched in 1972, directing implementation by 1974, thereby allowing three years for hospitals to gradually transition to the 1600-hour curriculum. In his announcement of the new curriculum the Chairman of the Victorian Nursing Council wrote a letter to all registered general nurses in Victoria (Patrick 1972, pp. 1-2) (see Appendix 7) advising:

> Most nurses holding practicing certificates know that the Victorian Nursing Council has prepared a new curriculum for the training of general nurses, and that the programme for its adoption provides that it will be applicable to all who commence their training in 1974. The enclosed pamphlet is to ensure that all practicing general nurses are aware of the extent of the preparatory work which has already been done towards the introduction of the new curriculum:

- The principles incorporated in it
- The progress being made towards its implementation

The newly published curriculum document was circulated with the following explanation being made (Patrick 1972, pp. 1-2):

> This curriculum results from the review and recommendations made by the Review Committee established in 1959. When undertaking the review it reached the conclusion that when her formal training was completed a nurse met demands of a range and intensity which were far beyond those of which that training had fitted her. To remedy this position the Committee recommended to the Council that major revision be undertaken. The patchwork of the existing regulations should be replaced by a planned and orderly programme; a cohesive pattern of education for the role which modern development in medicine and patient care requires should take the place of spasmodic response to particular needs which had sufficed when the role of the nurse was less sophisticated.

Russell (1990, pp. 142-7), when discussing the changing curriculum expectations that had occurred throughout various states of Australia, explained that there was a new era of resource management being confronted by most hospitals having student nursing programs and that the changes resulted in a financial impost because of the need to replace student nurses with other workers. Significantly, such an increase in the number of hours for which students were required to be in class meant a reduction in their availability to work in the wards as labour force.

STUDENTS CRITICAL TO HOSPITAL LABOURFORCE

Jayawardena, who was a visiting nurse leader speaking at a nursing conference in Melbourne in 1961, had made extensive comment about nurses as labour force. Jayawardena (1961, p. 306) spoke to the profession about the problem of using students as workforce, explaining that this resulted in students spending time on the ward doing routine repetitive tasks that did not always result in new learning:

> ... in my opinion the student nurses are asked to repeat their tasks well beyond the point at which skills have been acquired because there is work to be done and someone has to do it

The way in which trainees were used as workforce allocated to tasks rather than as learners was also the concern of the respondents in Nicholson's study of nursing education undertaken in 1992. One respondent commented that 'Junior nurses were concerned only with fluid intake and output of their patients and others had similarly focussed tasks that were common to a group of patients' (Nicholson 1992, p. 29).

Jayawardena (1961, p. 307) maintained that trainee nurses were being used as labour force to ensure the viability of the hospital rather than to give priority to their requirement for education, explaining that '... at present many hospitals would have to close down, without the labour - I purposely use the word 'labour' of their nursing trainees.' Jayawardena went on to explain that the hospital administrators believed that without students the already existing nursing staff shortages would be exacerbated (Jayawardena 1961).

After the launch of the Report of the Committee of Enquiry into Nursing in Victoria 1965 it became apparent that employer bodies recognised that students were critical to the financial viability of their organisations. It was in their interests to have students continue to be available as a part of their workforce. Some of the organisations were concerned that to fulfil the recommendations of the enquiry would mean that the number of annual intakes of student groups would need to be reduced by some hospitals. In a response to the enquiry RVCN (1970, p.12) acknowledged the concern of large hospitals who had claimed that the reduction from four or more intakes of students per year may:

> … gravely overtax their physical resources and adversely affect patient care, and that wards would be closed because of staff shortages. As an example, a submission made by the Committee of Management of the Royal Melbourne Hospital stated their firm opinion that the 1600-hours proposed ... will have far reaching effects upon staffing and financing of hospitals in the state and a detrimental effect on patient care.

The RVCN response demonstrated that, despite these concerns, the Victorian nurse leaders continued to advocate for trainees in hospitals to be recognised primarily as students. Rather than

maintaining focus on the needs of the hospitals they supported the recommendations of the enquiry in a submission to the Victorian Minister of Health (RVCN 1970, p. 12), particularly the recommendation that:

> As a pilot project, a course for the education of student general nurses, as full time students, should be conducted under the aegis of the Victorian Institute of Colleges.

Following the release of the report of the enquiry, the Country Hospitals' Association and The Metropolitan Hospitals' Association made a joint submission expressing their concern about the potential impact on hospital staffing should the curriculum hours increase (The Country Hospitals' Association and The Metropolitan Hospitals' Association 1971, p. 1) (see Appendix 8):

> In the first instance, we wish to state that we do not oppose the introduction of a new curriculum for general nurse training. We recognise that in order to meet the community's needs for the future that we will be required to educate nurses to a higher standard than at present: to better prepare and equip them to cope with the ever changing and advancing field of medical technology and, generally, to ensure that patient care and nursing service are kept at the optimum level

Although these organisations agreed that there needed to be a change in the nursing curriculum, in their correspondence to the Minister they expressed their concern about what they considered was going to be an increase in the financial impost on the services provided by them. According to these organisations the changes that would be required included increases to the number of educators, the reduction in the number of student groups and requirements for improvements in infrastructure to support the changes. The increase in hours meant that hospitals would need to increase their workforce to make up for the number of hours that the students would not be available for ward work under the new curriculum (The Country Hospitals' Association and The Metropolitan Hospitals' Association 1971, pp. 1-5).

The Country Hospitals' Association and The Metropolitan Hospitals' Association (1971, p. 4) indicated in their submission that they '… had been assured by the Minister that financial support would be forthcoming to cover increased costs.' However, despite this assurance, the Hospitals

and Charities Commission (1976), the entity charged with the administration of health care in Victoria, informed the group that they had put a case before the Minister of Health for his consideration stating:

> … that in the meantime, any additional expenditure incurred must be absorbed in the budget expenditure of the individual hospitals and met from the funds available to them at that time

There were concerns about declining nursing manpower available to hospitals to effectively run their hospital services and these concerns were further exacerbated with the introduction of the 1600-hour curriculum. The President of the Royal Melbourne Hospital was among those who were concerned with the increase in the number of classroom hours that had reached 1300 hours during the transition process in that hospital, explaining to the Minister for Health that this change had resulted in a need to close wards because there were not enough available nurses (Frew 1976) (see Appendix 11). The President predicted that this situation would be exacerbated further with the increase to 1600 hours of classroom time for nursing students.

The decision to increase hours without an opportunity for additional funding of hospitals had the potential for setting the employers against the progression of nursing education. It had the potential to impact on the continued support for the changed curriculum by organisations such as The Royal Melbourne Hospital and the Country Hospitals' Association and The Metropolitan Hospitals' Association whose members administered some hospitals in Victoria. They would be responsible not only for increased staffing costs but also for the need to support nurses to undertake community health placements in organisations such as the Royal District Nursing Service and to improve education resources without financial support from government.

APPROVAL TO IMPROVE NURSE EDUCATION IN HOSPITALS.

Whitfield (1969, pp. 1-2), reinforcing the position of the Nursing Education Section in the submission to the Minister of Health, stated that if there was to be an improvement in the curriculum after so many years there would need to be adequate numbers of appropriately educated nurses to teach the curriculum, and to support those students who had been voicing concern that they believed their tutors not to be adequately qualified:

> …the present staff establishment of schools of nursing, as stipulated by the Hospital and Charities Commission is hopelessly inadequate and affords no opportunity to encourage and prepare potential nurse educators for any proposed improvement in curriculum.
>
> Those of us who have daily contact with student nurses are becoming increasingly concerned because of the wave of student unrest … This is largely brought about by unreal demands made on their time and energy, and because they are currently ill equipped to carry the responsibility expected of them.

Approval was granted at the time of the release of the new Victorian curriculum document for an increase in the number of registered nurses employed in schools of nursing, as well as support for additional nurse educators to become qualified to help meet the requirements of the curriculum (Patrick 1972).

In addition to specifying the required numbers of educators against student numbers, classrooms, staff offices and library facilities there was to be a commitment to properly correlated theoretical instruction and clinical experience. Limitations were required to be placed on the time that trainee nurses spent on night duty, and there were also other significant aspects relating to the new curriculum implementation. Patrick (1972, p. 2) advised the reasons for this as being:

> … to ensure that during the student's course the minimum period of 1600 hours in which her formal instruction is to be given and not eaten into by time spent as part of the nursing service staff, also to ensure there was a comprehensive range of subjects to be studied and applied, and a range of specified clinical area be offered to the students

In 1973 all institutions wishing to participate as schools for nurses were advised to make application by June 1974 for approval. The minimum education level for entry to training was raised to Leaving Certificate (year 11) (Patrick 1972, p. 3).

Among the many important outcomes that occurred at the time of the implementation of the new curriculum, also recognised by Patrick (1972, p. 2) was:

> … the number of hours devoted to instruction has been substantially increased in most training schools: at present time at least 20 schools teach beyond 1000 within the 40 hour working week, another was that with this new approach to curriculum came the directive that no school should take more than 3 intakes per year.

The introduction to the new curriculum document by RVCN (1970, p. 29) concluded:

> While nurses trained in the last 10-20 years have reason to be proud of their success in making the best of the preparation given to them in their course, they may feel a pang of jealousy at the opportunities which will be available under the new curriculum. They will be the first to acknowledge that the education of nurses generally has not kept pace with the changes made in the treatment of patients and the techniques in medical and surgical care.

This information brought to light for me the realisation that students were critical to staffing and patient care in some hospitals. Up until this time I had not consciously thought about what my apprenticeship had really meant to the hospital where I worked as opposed to what it meant to me.

It was not until I was employed for the first time in South Australia in 1977, which is explored in Chapter Five, that I became aware of the lobbying for change that had been occurring over the previous years and which was escalating at that time.

The new curriculum in Victoria of 1600 hours of classroom time in hospital-based courses was released in 1974. This coincided with the introduction of the pilot programs being conducted in CAEs, as reported in the Committee of Inquiry into Nurse Education and Training (Dr S Sax, Chairman) Report (1978, p. 3) in stating:

> 1.11 Since 1974, six pilot courses in basic nurse education have been established in colleges of advanced education. The courses are at the Lincoln Institute of Health Sciences and the Preston Institute of Technology in Melbourne, the Sturt College of Advanced Education in Adelaide, the Western Australian Institute of Technology in Perth, the Riverina College of Advanced Education in Wagga Wagga, and the Cumberland College of Health Sciences in Sydney.

Dr Ruth White, the first Head of The School of Health Professions Sturt College South Australia, explained the changes that were occurring in South Australia in her Oration in August 1979:

> Nursing at Sturt began in February 1975 with the 3 year Diploma of Applied Science (Nursing) with 56 students. The course aims to prepare students for the general register of the Nurses Board of South Australia and also to enable them to obtain a basic Diploma (UG2 level) as that is recognised by the Australian Council of Advanced Awards.
>
> A bridging course for RNs followed in 1977, the graduates received a Diploma of Applied Science (Nursing). In that year also the Diploma of Applied Science (Community Health Nursing) and Diploma of Teaching (Nurse Education) commenced. In the following year, nurse educators entered the Bachelor of Education. Following is the structure on which courses at Sturt are built e.g. Students were given recognition of prior learning to do the Diploma programs doing 1 year part time and one year full time. The Degree programs were run for 3 years part time.

I became aware of the initiative to introduce college-based education and the establishment of the Goals in Nursing Education Task Force when I was first employed in South Australia in 1977. In the next part of this chapter the goals and their impact on the transition of nursing education to the higher education sector are shared.

NATIONAL MOVEMENT FOR CHANGE

GOALS IN NURSING EDUCATION

The Goals in Nursing document was an important document used for lobbying for the advancement of nursing education in Australia in the 1970s. I had not seen it prior to it being introduced to me by the Senior Clinical Teacher during my orientation to a South Australian hospital in 1977. This orientation is explored further in Chapter Five of the thesis.

The Goals in Nursing Education were developed by a task force of national and state-based nursing associations involved in initiatives designed to influence the government to transition nursing

education into the Advanced Education Sector. These were CAEs and Institutes of Technology in each of the states of Australia. ‘In 1973 a working party was established by the Royal Australian Nursing Federation and the College of Nursing Australia, to prepare a document on goals in nursing education’ (Donaghue 1975, p. 1). This work had commenced four years prior to my employment in this hospital. The working party was extended to four professional organisations to include the National Florence Nightingale Committee of Australia and the New South Wales College of Nursing. The Goals document was ultimately developed following a national survey which was undertaken by Donaghue to ‘... gather views of key officials throughout Australia on developments in nursing education’ (Donaghue 1975, p.1). This document gave me my first insight into the work that had been occurring in each of the states in recent years. The overall direction of the Goals was that by 1986 all nurses training for registration or enrolment would be full-time students, rather than employees of a hospital.

Based on the information given by Donaghue (1975) in the introduction to this document, I realised that I was probably not the only nurse ignorant of the strategic position of the nursing organisations. Donaghue (1975, p.1), when introducing the results of a survey of members of the nursing profession as a first activity toward developing the Goals in Nursing Education document, concluded that when she was seeking information about the current status on nursing education in each of the states ‘... the nursing organizations concerned were unable to assemble adequate material about current proposals for change’. Donaghue (1975, p. 1) explained that the various organisations did not have the necessary information and did not engage members of the profession in formal discussions about their intentions because they believed that ‘... discussions were informal, and proposals being considered could not be made public.’ When finally revealed, the first finding of the survey broadly aligned with the understanding of the Task Force members at that time, which according to Donaghue (1975, pp. 91-3) was:

1. The nursing profession is unaware of and inadequately involved in nursing education developments:

- An extremely small proportion of the study sample perceived nurses to be interested in or to understand implemented changes,
- Although selected personnel were perceived to be influential in promoting the discussed changes, respondents frequently indicated that nursing personnel were not involved in preliminary negotiations,
- Several nursing respondents were unable to answer questions about proposed, implemented or desired changes in nursing education.

2. The nursing profession currently is not able to develop appropriate nursing education programmes to meet the nursing services needs within the present system of health care.

3. Neither the community nor the nursing profession is prepared adequately to accept proposed, implemented or desired changes in nursing education.

4. The nursing career structure is not compatible with the proposed developments in nursing education.

5. At the present time, the professional organization is not fulfilling an appropriate role in relation to professional education and development.

Findings two, three, four and five of the survey show the potential for conflict that could occur within the profession if the information was not shared with members of the profession. Each of these findings included subpoints that are not all listed here however some are explicated in other parts of this text.

These responses are interesting especially considering the move by the Task Force to change the direction of nursing education. It is interesting that people in such important leadership roles in the various states did not see that part of their leadership responsibility should include finding ways to engage with the rest of the profession to gain a universal understanding and ultimately a commitment to the change. A goal that may have the potential to limit conflict in the profession.

The resultant survey findings were taken into consideration when the Goals statement was developed. The resultant Goals statement advocated that a tertiary qualification was necessary for

the basic education of the professional nurse. According to McCoppin and Gardner (1994, p. 89) the recommendations:

> … were included in the first publication of 1975, of the Goals in Nursing Education Part ll. It set out a five-stage program (1974-1991) for moving nurse education out of hospitals and regional schools and into the general education system and moving education to the higher education sector during the years 1975-1985.

The stated aim of the program plan combined improving the quality of nursing care and ensuring that nursing education was equivalent to that of other personnel in the health team.

In subsection 3c of the findings of the Goals in Nursing Education Task Force survey of 1975 it was identified that concern had been expressed by the respondents at the lack of encouragement of students of hospital-based programs in Australia to be creative decision makers - essentially to be critical thinkers. Donaghue (1975, p. 92) wrote in the findings:

> The present system of nursing education was seen by numerous respondents to militate against the development and acceptance of innovation education programmes. Qualified instructional staff are basic to the development of sound education programmes. Yet respondents did not perceive that the present system produced teachers in nursing with appropriate qualifications to fulfil their role. Moreover, the existent system was seen to discourage decision-making creativity and a scientific approach, and to encourage non-questioning acceptance of authority and the status quo.

This situation was very evident during my education to become a registered nurse, as is recognised in Chapter Three of this thesis.

It is difficult to ascertain how far and wide these goals were discussed among members of the profession following their publication however there was one conference held in the Australian Capital Territory (ACT) by the Canberra Continuing Education Centre at which there was significant discussion held (Duke, 1975). This conference '... marked the culmination of a protracted discussion among ACT nurses about the report' (Duke 1975, p. 9).

The participants at this conference were asked several questions about how they believed nursing education should be conducted in the future. There were a variety of opinions held regarding the

institutions where this education should occur, including continuing the hospital-based programs, commencing college-based education or alternatively finding a way to combine both and getting what might be considered the best of both approaches. Of major importance was that no matter which approach was decided there should be an emphasis on correlating theory and practice. Of significant concern was that if hospital-based education was to continue there should be a separation of the nursing school from the hospital administration, with a specific budget allocated for nursing education, and that educators should have appropriate education and skills. There was also a call for students to be supernumerary in any nurse education system. Duke (1975, p. 10) explained that among the respondents 'Cheap unqualified students of nursing ("slave labour") were mentioned often.' It was also stated that 'The student nurse in a service role is not in fact getting experience relating to what she is supposed to be learning' (Duke 1975, p. 10). There was also a call for adequate clinical experience to be a priority in any program. One respondent to the questionnaire that had been administered prior to the conference acknowledged that there could be an improvement in the types of subjects and education offered in the colleges and continued arguing for college education over university education, little knowing that a government decision would soon be made to amalgamate colleges and universities. The respondent was quoted by Duke (1975, p. 13) as stating:

> I would prefer to see nursing education in Advanced Colleges rather than Universities as Colleges appear better equipped to handle the movement of students in and out for practical components.

At the time of my employment with Village General Hospital (VGH) (pseudonym) in 1977 (see Chapter Five of the thesis), I became aware of these events and it turned out to be very auspicious for me because I was surrounded by nurse leaders engaged in the lobbying for the transfer of all pre-registration nursing education into the higher education sector. I became an active participant in the lobbying and became a student of the first nursing education diploma to be offered in South

Australia and later became involved in the movement for change. Undertaking a higher education qualification was significant for me because I had previously had only ten years of schooling. I undertook and passed a mature aged entry examination, enrolled and two years later completed the Diploma of Teaching (Nurse Education). I was the first in my family to go to college. I have now competed three higher education qualifications.

The story of the progress made by the lobbying of the Task Force traversed a period of eleven years from its initial establishment in 1973 to the announcement by Government in 1984 giving in-principle support to the full transfer of pre-registration nursing education to CAEs and to the disbanding of the Task Force in 1984.

In August 1984 the Task Force received a press release produced by ministers of the Australian Government. It was a joint initiative of the Minister for Health, the Minister for Education and Youth Affairs and the Minister of Employment and Industrial relations on 24th August 1984 and headed '*Government Announces Decisions on Basic Nurse Education*.' In the press release in-principle agreement was given for the transition and a process was set in place. It included a statement announcing that the last intake into hospital-based courses would occur in 1990 and that the '... full transfer will be completed by 1993' (cited in Cochrane 1984a) (see Appendix 9). The ministers acknowledged that there was potential for the transfer to impact on both hospitals and colleges. They stressed that it was necessary that the transition should occur over the time identified so as not to '... create severe shortages of trained nurses because of the need to replace student nurses working in hospitals or overstretch the resources in the education institutions' (cited in Cochrane 1984a).

Because of the years of agitating for change through the lobbying undertaken by various nurse leaders it must have been exhilarating for them to read the positive outcomes that the

government expected to accrue because of the changing approach to nursing education. In the press release (cited in Cochrane 1984a) it was revealed that:

> The Government expects that significant benefits will result from the transfer, including a better and more flexible nursing workforce, increased employment opportunities for nursing personnel, increased educational and vocational opportunities, particularly for women, and an enhanced status for nurses to bring them into line with other health professionals.

According to Russell (2000, p. 21) 'The Federal Government agreed to become responsible for funding these programs across Australia.' On 7th November 1983 New South Wales had been the first state to announce the full transfer of all pre-registered nursing programs. In 1985 twelve CAEs and one university offered the Diploma of Advanced Education, Russell (2000, pp. 20-1), explaining that the transfer occurred across Australia at 'varying rates' with the transfer complete in 1993. The last intakes of hospital-based programs in New South Wales occurred in mid-1984 and these students graduated in 1987 (Russell, 1990). Queensland accepted the last intakes into hospital-based programs in 1990.' (Russell 2000, pp. 20-1).

Within days of the announcement of the in-principle agreement the National Convenor of the Task Force (Cochrane 1984a) wrote a memorandum to the advisors and Task Force conveners, including a press release for their information. The memorandum congratulated the members and advisors of the Task Force and thanked '... all who have assisted us to gain this major political victory' (Cochrane 1984a, p. 1). The memorandum announced the intention of holding a meeting in the future '... to conclude the activities of the National Steering Committee/Task Force structure now that the major objective for which it was established was achieved.' Cochrane (1984b, p. 1) wrote again to the advisors and Task Force conveners announcing that the meeting would be held in December '... to formally bring to a close the National Steeting (sic) Committee Task Force Structure.' (see Appendix 10). Cochrane (1984b, p. 1) attached the 'Commonwealth Offer' statement with the memorandum and concluded it by stating:

> The terms of the Commonwealth Offer, (copy attached), make it clear that from here on most of the activity needed to ensure the achievement of the total transfer of basic nurse education to the higher education sector by 1993 will need to be undertaken at the State or Territory level.

However, some disruption was experienced while the first stages of the transfer were in progress. In 1987 the Commonwealth Government announced its intention to abolish the advanced education sector (Reid 1994). The advanced education sector was comprised of CAE's and Institutes of Technology, as opposed to the higher education sector which referred to universities. According to Reid (1994, p. 31):

> It abolished the advanced education sector (where nursing courses were housed) as a separate component of the system: advanced education institutions were encouraged to either join existing universities or to become new universities with the full range of teaching, research, community service activities traditional to the sector.

Many years after the disbanding of the Task Force, the Goals were acknowledged by nurses interested in the history of progress made in nursing education. Among them was Piercy (2002, p. 236) who recognised in her thesis about the development of nursing education in Western Australia that 'The Goals in Nursing Education working party was the first overt sign that nurses nationally were united in taking an active stance in determining the future of nurse education.' Piercy (2002, p. 240) supported the establishment of the Goals, explaining that setting of the Goals was a way in which the nursing profession took some control of its destiny, when she wrote:

> … with the setting of national goals of nurse education that proposed that all nurse education be moved to institutes of higher education nursing was no longer going to take a back seat in determining its own destiny.

Nursing was not only transferred to higher education but also transformed from an advanced education discipline to a university discipline and from diploma status to degree status. In that sense the preparation of registered nurses was shifted further from its origins in the health care sector than some might have expected. Reid (1994, p. 33) challenged nursing to engage as a profession into the new arrangement, explaining 'In the Universities nursing can more fully develop a research base, which is crucial to the development of the nursing profession'.

CONCLUSION

This chapter has detailed, primarily by using archival material, the changes in nursing education in Australia over a thirty-year period. It provides insights into the various initiatives that took nursing education from hospital-based programs through to college programs offering diplomas and eventually to bachelor's degrees in universities with practical experience now being negotiated with the health care sector.

CHAPTER FIVE - TRANSITIONS

> The present system of training in hospital focuses on the care of the sick, but prevents nursing students from learning skills essential to communicating with the patient, putting their knowledge to best advantage and giving greater depth of nursing.
>
> (Durdin 1980, p.1)

INTRODUCTION

I graduated as a registered nurse in October 1967 and found myself on a new journey of discovery. This was a time when nursing was on the cusp of a change that would herald in new approaches to nursing practice and nursing education. This change was identified by many nurse authors, some of whom include Durdin (1991), Goldsworthy, Pickhaver and Young (1984), Reid (1994), RVCN (1970) and Russell (1990, 2000).

In Chapter Three, which spanned the three-year period of my nursing training, I shared my journey of becoming a registered nurse. The stories in Chapter Three showed that when I was a student I was educated essentially with a focus on body work and cleaning. During the ten years following graduation from 1967 to 1976 I had varied experiences as a registered nurse. I noticed significant change in practice to that which I had learnt as a student even though I had a glimpse of change during the final month of my training. This practice was a result of new human biological information, pharmacology and medical technologies that were occurring and impacting on medical and nursing practices. This chapter begins ten years after graduation at the time of my employment for the first time in a hospital in South Australia and carries on with my nursing education journey to 1994.

MY TRANSITION BEGINS

A NEW REGISTERED NURSE ROLE

In December 1976 I moved to South Australia with my family. It was a Monday morning in April 1977 and I was sitting in the front office of the Village General Hospital (VGH) (pseudonym). I was dressed in the white nursing uniform of a registered nurse waiting for the senior clinical teacher who I had been told would be meeting me there. As I sat there I watched a woman dressed in a blue uniform and wearing a blue paper cap walk towards me down the corridor. She stopped in front of me and asked:

'*Hello, are you Lesley Siegloff?*' I nodded and stood.

She welcomed me to the hospital and told me her name (for the purposes of this story I will call her Margaret (a pseudonym) and that she was the senior clinical teacher and hoped that I would enjoy my new role as a member of the nursing staff of the VGH. She explained that she would be running the orientation program, handed me a sheet of paper with the program for the next week detailed on it and asked me to accompany her. I told her that I was really pleased to be there that morning and was looking forward to learning more about what my role was to be in the hospital, especially so because I had been notified only on the previous Saturday to report to the hospital to take up a position and I knew very little about VGH.

This was the first time in two years that I had been employed by a specific hospital. My previous job in Melbourne was with a nursing agency. I had worked like this because it was the only way for me to work while raising two young children. My husband and I had no extended family support and there was limited child care to help us if we were both out at work at the same time. I was able to get shifts from the agency on the days when my husband was on leave or having days off from work so that he could look after the children while I worked.

My husband, our two young children and I had arrived in South Australia in the week prior to Christmas in time for my husband to take up a new position with his employer in Adelaide. After we had been in Adelaide for two months I had decided that I needed to go back to work. I had found that, unlike Melbourne where I had difficulty accessing child care, in Adelaide there were child care centres where carers were available to transport school-aged children to and from school. This meant that we would be able to have our children, who were seven and six years old, cared for if I took a shift work job. Having made the decision that I would try to find a registered nurse position somewhere in Adelaide I looked at the advertisements for nursing positions in the Adelaide newspapers. I realised quickly that there were very few positions available for registered nurses in suburban Adelaide at that time. I decided to try to find a position by cold calling some of the hospitals in the city. After a few weeks, and after many rejections, I was eventually invited by the recruitment officer of VGH to present for an interview. I was interviewed on a Friday by the Deputy Director of Nursing who, at the completion of the interview, told me that there were no positions available at that time but if one should become available she would contact me. That call came sooner than I expected. On the following Saturday morning I received a phone call from the Deputy Director of Nursing who explained that there was a position for a registered nurse available after all and that I should report in a white uniform to the reception desk of the hospital to take up a position as a registered nurse on the following Monday morning. I asked if I was to wear a veil or a cap. She explained that I would be supplied with paper caps on employment.

On that first morning Margaret took me on a tour of the hospital and told me about the orientation program that would be run on the Thursday and Friday of that week. In the meantime, I would spend time on the ward that I had been allocated to - a vascular surgical, plastics surgical ward with four high dependency beds. After the tour of the hospital Margaret took me to the ward and introduced me to the charge sister. After Margaret left the charge sister took me into

her office and started her welcome to the ward by informing me that she didn't know why I was there because she didn't have a vacancy in the ward at that time. I remember her words that '*there is no job here for you'*! I was really surprised. I thought that because I had been told to present for orientation there must have been a vacancy. Even though she questioned why I had been allocated to her ward, the charge sister sent me on my way with one of the enrolled nurses who she had instructed to show me around and to orientate me to the ward. This was my first time of working with enrolled nurses and it was interesting to see that their role was at times like the work done by student nurses. Unlike the education for registration that the student nurses were undertaking the duration of the enrolled nurse training program was for twelve months only. Like the student nurses, the enrolled nurse was also responsible for the hygiene care of the patient, however they had some limitations in their practice as they did not perform procedures such as wound management or administration of medications. Students were given training in medication management during their second year and were supervised in that hospital to administer medications by clinical teachers.

When the enrolled nurse showed me around the hospital she explained the various expectations of the charge nurse and the way in which task allocation and team nursing was used in that ward. It seemed to me that she was the messenger for the charge nurse.

> *I was quite concerned when the enrolled nurse was identified as the staff member who seemed to be the nurse most appropriate to orientate me to the role of the registered nurse in that ward. It seemed that no distinction was being made between the expectations of the roles.*
>
> *I spent the rest of the week until orientation finding my way around. I am not sure why they employed me but ultimately even though there didn't seem to*

be a job in the ward at the time I was a member of the staff of this ward for the next ten months.

GLIMPSE OF A DIFFERENT EDUCATIONAL APPROACH

It was good to be doing an official orientation program. This was the first time in the ten years since my graduation that I had been offered an orientation program. I had worked in many hospitals in various towns in Victoria and New South Wales in those years and one of the most difficult issues was getting to know how each was run. Hospitals, like other institutions, had their own idiosyncratic way of doing many things. Orientation meant that I had an opportunity to focus on the idiosyncrasies of this new place of employment. As it turned out I would learn much about this organisation and even be involved in shaping some of the procedures in the future because I spent seven years there and eventually became a clinical teacher and later the in-service educator.

Over the following days I also studied Margaret's role as the senior clinical teacher. I had become aware of the emerging clinical teacher role in nursing when I was working in New South Wales as a registered nurse in 1975.

During the orientation program Margaret and I made a good connection. She seemed very enthusiastic about sharing all that she knew about the changing face of nursing education and she ultimately was instrumental in my decision to engage with the changes in nursing education that were occurring at that time. She was my first nurse mentor and introduced me to the ideas that opened my eyes to the profession's commitment to changing the education path of nurses in Australia.

Among the changes we discussed was the introduction of a pilot undergraduate nursing program that had been established in 1975 in the nearby local CAE. Initially I was confused about what I was hearing because I was aware that VGH also ran a three-year pre-registration hospital-based nursing training program.

> *I was confused by what she told me because I couldn't understand how two different types of nursing programs, one from the college where the graduates obtained a diploma and the other from hospitals where graduates received certificates, could lead to the same qualification and ultimately registration with the Nurses Board of South Australia. I was also confused as to how these two different types of graduates would compete after graduation for the same first-year registered nurse vacancies at the same salary.*

Margaret explained that the profession was characterising the two approaches to education as a binary system with the same registration outcomes and that there was a similar concern held by many members of the profession. In Margaret's opinion the binary system of nursing education with the continuation of the hospital-based programs alongside the college courses would be short lived. The intention of the profession was to work towards all nursing courses leading to registration, as well as post graduate community health and management diploma programs, being run in CAEs rather than hospitals. She told me that the pre-registration nursing program in the local college had commenced taking students in 1975 and it was expecting the graduation of the first cohort to be in 1978. She also explained that students from the college program were having clinical experience in the general hospitals where they were working alongside the student nurses doing the hospital certificate. However, unlike the hospital-based students, the college students' experience was being expanded into the domiciliary nursing services and community health centres in the metropolitan area.

At this time, I was also introduced to the college clinical teacher who was supervising the college students on the wards of the hospital. The VGH was an important clinical venue for the pilot college program. When Margaret introduced me to the educator she told me that this nurse educator had been instrumental in writing the curriculum for the South Australian Sturt CAE program. I learnt as I listened to Margaret that although the college administrators had been able to negotiate placements for college students in the VGH and the hospital in which the pilot college program had been temporarily co-located, they had been hitting some obstacles in trying to get these students placed in some other hospitals and community services around the state. They were looking for a variety of experiences for the students so that they had a broad-ranging understanding of care needs of patients across the health care sector including community health and domiciliary care. According to the clinical teacher this situation had been caused because there was no official connection between the college and the hospitals, and that negotiation with some hospitals was difficult because most of them already had their own students. Goldsworthy, Pickhaver and Young (1984, p. 2), when writing about the introduction of the local college program, identified that:

> ... nurses must be prepared to provide nursing skills in any situation, in or out of the institution. The program was designed with a view to enabling graduates to achieve this outcome so diverse negotiations were critical.

During the time spent with Margaret we discussed the evident disquiet that existed in the wards at that time regarding the different expectations being placed on the two student groups who were often working on our wards at the same time. It was evident that there was often confusion about what the college students were learning. Margaret explained to me that, although the hospital-based and college students worked alongside one another on the ward, they each had different objectives to achieve. Also, even though both worked alongside one another when they were on the wards, there were differences in their programs. The college students were not

employees of the hospital and therefore did not receive a wage for their work. The college students who were categorised as full-time students spent two days a week on the wards, but only in semester time. This was quite different to the hospital-based students who were both employees and students and were rostered over a seven-day period. They did not have full student status however they did have financial security through employment in their hospital.

> *I came away from this discussion wondering how there could be such differences in the way the two groups were being educated ostensibly for the same role. When the whole issue eventually sank in for me I realised that when they graduated the nurses from both groups would be looking for the same registered nurse positions. There did not appear to be a distinction being made between them and there were no special arrangements being made to identify a different role for the college graduates. However, when I thought about it later I recognised that this was a new situation that was only just being introduced to the health care sector and nursing. I thought that in the future this situation might change, especially if the plan to have all nurse education transferred to the higher education sector was successful.*

As my ward orientation went on I saw Margaret often. She worked alongside me from time to time so that she could review my skills such as patient care documentation, medication management and wound care. When she did this she also took the opportunity to introduce me to the Nursing Process, a new nursing practice approach that had recently been introduced to the nursing staff of the hospital. Even though I had been happy to be given the opportunity to learn about the hospital, the focus on checking my clinical skills made me feel like I was starting nursing all over again. However, I realised quickly that I did need some information about the documentation system being used, which was based on the new Nursing Process. This was a much more complicated approach to documentation than I had encountered previously, when I was just

required to make notes of care given and medications administered. The Nursing Process was being implemented widely in hospitals around Australia and was being promoted as a framework to guide nurses to undertake a systematic approach to nursing care and documentation.

As well as learning about the systems used in the hospital our conversations became quite far reaching. I remember her walking alongside me when I was doing a medication round. She stood beside the medication trolley showing me the documentation system and at times interspersed her conversation with information about how nursing practice was changing and how important it was for nurses to be active in guiding some of the changes.

Even though I had experienced some confusion about the two approaches to pre-registration nursing education Margaret inspired me to think about nursing in a different way. She explained that the current situation was occurring because the current college program was a first step, and because it was a pilot program. Margaret confidently reassured me that the binary situation would change in the future when agreement was reached with government to make the compete transfer of education into the higher education sector.

In the following months I realised that I had landed in the right place at the right time. At no other time in the past ten years had any nurse leader spent any time with me teaching me or talking about the future of nursing with such enthusiasm. It was intoxicating, especially when she talked about the many members of the profession who were committed to changing the way in which nurses were being educated to become registered nurses.

On reflection I realise that for me this experience was like having a light turned on. I had hung on to her every word thinking this could be the way forward for the future and maybe if I had this experience when I was a student I may

have been surer of myself and less concerned about my competence. I may have been able to take a more problem-solving approach to each new experience I had rather than always second guessing my knowledge as I had been doing over the years.

Margaret seemed to be especially proud of the South Australian nurse leaders when she told me that most of the senior directors of nursing of Adelaide metropolitan hospitals including the Director of Nursing (DON) of this hospital, were actively working through professional nursing organisations to influence the government about the importance of changing the way in which nurses were being educated. She explained that the DON was so committed to seeing the advancement of the education of nurses that she was at the time studying at a higher education institution in Sydney for the Master of Health Administration herself. According to Margaret, the DON was showing the way to her staff and encouraging them to undertake continuing education. She was instrumental in gaining funding for this education for many of the nursing staff members. Margaret also demonstrated her own commitment to improving opportunities for nurses' education, telling me that she was a member of two of the professional organisations involved in working towards the change - the College of Nursing Australia and the Royal Australian Nursing Federation. She explained that there was a close alliance and strong links between both industrial and professional nursing organisations. She informed me also, as we worked together, that most of the directors of nursing and other senior nurse leaders of hospitals, the department of health chief nurse and lecturers at the college were active members of at least one, and in many cases both, of these organisations. Some years later Durdin (1991, p. 257), when supporting the collaborative approach taken by these nurses' associations, declared that this reflected nursing becoming professional, in writing that 'Collaborative efforts are a mark of professional growth.'

I became so enthusiastic about what I was learning from Margaret about nursing that I joined one of the professional organisations. This decision and others that followed because of her inspiration resulted in my becoming very involved in some of the activities relating to the transfer of nursing education to the higher education sector.

I couldn't have foreseen how important this employment opportunity was to be for me.

In the early days of my employment at that hospital I began to realise that I had not been conscious of the direction that the profession had been taking during my short career. I was very naive professionally and out of touch with the work of the profession and must have been ripe for change.

Reflecting on my employment in this organisation I realise that my seven years of employment there was a significant time of education and growth for me. This could be attributed to my being in a place where I was appointed for the first time to a substantive and permanent position and consequently able to become an active participant of the nursing team. I attribute this good fortune to the clinical teacher's inspirational approach to teaching and the strong leadership of the director of nursing. She showed this leadership through her own pursuit of education and commitment to the continuing professional education of nurses she employed.

In later years I have encouraged other nurses to seek out a mentor to work with during their career. I believe that my experience with Margaret was instrumental in the way in which I continued to engage throughout my career to actively work, through professional nursing organisations and education, for the advancement of nursing.

At one point in her discussions with me in the ensuing months Margaret introduced me to some of the documents and articles that focused on the changes in the approach to nursing education in Australia. She highlighted for me the attempts that the profession was making to have more control over the future of nursing education than those that they had been able to accomplish previously. At this time, she told me about a Task Force that had been established in 1973 and which had developed the Goals in Nursing Education. I then realised that there was so much more going on in the profession than what I had realised and that I should keep my eyes and ears open to this new information. At that time, I became more interested than I had ever been before in reading the nursing journals that I had seen on the coffee table in the nurses' sitting room in the hospital.

> *I didn't realise at the time of being introduced to the information about the Goals and directions in the early days of working at VGH in 1977 by Margaret what an impact her information would have on my professional journey. Her enthusiastic encouragement changed my life. When I commenced working at VGH I did so essentially because I was a registered nurse and knew that I could improve the family's financial circumstances by doing the work for which I had trained. As time went on I realised that my understanding about the profession of nursing was changing and that I not only wanted to work because of the financial outcomes but also because I wanted to work for the profession.*

REMEMBERING – THE FIRST TEN YEARS

Because she had been so open and very encouraging of me I shared some of my memories of my early years of being a registered nurse with Margaret. I told her that since graduation I had often felt that I was not a very skilled or knowledgeable registered nurse. I explained that I had often been confused about certain medications and their relationship to patient treatments. It was common for me to feel uncomfortable about talking to doctors when they expected me to give an

opinion of what I was seeing and why. I shared with her that I always feel comfortable doing general nursing care such as hygiene care and routine nursing practice and that I thought I was very good at time management in the ward and completing the general care required to make the patients comfortable.

When I first saw a clinical teacher on the ward in the hospital I was delighted. I shared this delight with Margaret, telling her that I had seen these nurses before and was interested in the role. I told her that, although I didn't always know about the medications and science behind patient care, I would love to work on the wards with the students to teach them about good nursing care. I saw myself sharing knowledge with students about making patients comfortable and ensuring that their care was undertaken in a timely fashion. While it is not the actual conversation, in the following section I describe what I talked to Margaret about regarding my experiences from the previous ten years working as a registered nurse in hospitals in Victoria and New South Wales, and what I learnt about nursing and myself.

Advances in science and medical technology changed me

Over the first decade post-registration I gained some rudimentary knowledge about nursing patients who were being cared for by using some of the new technologies of which I had little experience during my training. In my first role as a registered nurse in 1967/68 I was working in the operating theatre in a hospital in regional New South Wales. I had applied to work in the operating theatre because my experience as a student and as a first-year registered nurse had been very positive. I felt comfortable working in operating theatres. Over the ten years it became common to see the introduction of new technology every few months. In this role I worked primarily as a junior theatre sister setting up for surgery and cleaning instruments and trays and preparing them for autoclaving. Sometimes I could assist the surgeon by passing and holding instruments during the surgery. I felt well able to do these activities. At times I felt like an

automaton just as I had sometimes as a student, especially as I passed instruments, albeit a very competent one. This hospital also had a nurse training school and I was responsible for guiding the students through their clinical learning in the operating theatre.

> *I remember really enjoying the time I spent with the students showing them how to set up trolleys and trays for specific patient operations and how to keep the operating theatre clean and tidy. This was my comfort zone. I knew how to do this type of teaching, especially how to clean, which had been so much a part of my experience of becoming a nurse and of my childhood. This first experience of teaching students in the operating theatre made me feel worthwhile. I found their interest in learning about the work made my life more interesting. I was encouraged by the feedback that I received at that time from students, especially from my sister who was a contemporary of the students. She told me that her friends Sue and Carol were enjoying working in the operating theatre with me because I took time to teach them. I became very motivated by what my sister said and often reflected on it as I continued my nursing journey during the next decade.*

During my employment in my first year as a registered nurse I also did some shifts on the wards and was exposed to many new machines. As I learnt about the new technologies in that year my limited knowledge about how they worked frustrated me. I continually looked for ways to resolve my knowledge deficit, especially in relation to how these new technologies impacted on patient care. I spent some of the time between operation cases asking the anaesthetist's orderly about the machinery and tried to be in the room whenever the surgeon was talking to the residents about the surgery. I realised that I had made a good decision to do the Intensive Care course in Melbourne later in the year. Unfortunately, although I did commence the course, I did not complete it because I left the course early because of a family death. As a result, I returned home

and commenced work again in the regional hospital without the knowledge that I was looking for and did not return to complete the course. Consequently, I missed my first opportunity to improve my knowledge and to gain a nursing specialisation.

> *I had recognised from the time I was in third year that I should expand my knowledge but unfortunately had not completed the Intensive Care Course. However, I also knew that I had wanted to do that course because I had seen that my education was inadequate. Essentially, I had come to realise over the years since graduation that what I was looking for should have been included in my training and not having to rely on an Intensive Care Course to fill that gap. Looking back at the introduction to the course I remember being overwhelmed by some of the things that the educator assumed that I should know and that the course was a step further than the pre-registration course.*

My feelings of inadequacy continued and came into sharp focus for me when I took up a new position in another regional town in New South Wales in 1974. Ironically, given my aborted Intensive Care education and even though I had been employed to work in the operating theatre, I was rostered to work some shifts in the small four-bed Intensive Care Unit. There I found myself responsible for nursing patients who were being monitored on a *Bird* Respirator and/or cardiac monitors. I had seen each of these machines used in the operating theatre in my previous position, but I had no idea how they worked. What I did know was that the *Bird* Respirator assisted the patient to breathe and the cardiac monitor showed what was happening with the patient's heart, however I couldn't read the monitor or identify cardiac complications. I needed to learn quickly because I was often left alone in the unit to look after patients, especially when the registered nurse in charge went on meal breaks. I was very nervous and therefore concentrated more on what the machines were doing than on what was happening to the patient. When I was first introduced to working with the *Bird* Respirator the registered nurse who was orientating me

on its use told me to ensure that at all times when it was in use that each of the three dials on the respirator remained set at fifteen, while also ensuring that the endotracheal tube was not dislodged and to take hourly observations of the patient. With these meagre directions, I worked diligently to do what was expected of me, having no real idea what the results meant or how the machine was working.

> *Every time I asked for clarification about what was happening to the patient the registered nurse would confidently tell me about the workings of the machines. Unfortunately, she used what to me was a new language when talking about pressures and the process of respiration and the electrical conduction of the heart. I could never grasp the fundamentals.*
>
> *At times I felt like giving up, especially because I was concerned about the potential for me to misinterpret the cardiac monitor information. I was always worried that I would be proven incompetent. Consequently, for the first time since graduation I purchased some text books for study to make sense of the new language and practices.*

Clinical teachers influence my future decisions

Changes to technology that supported nursing care were not the only changes that I encountered in that hospital in 1974. One evening I was rostered to relieve in the medical ward. While I was walking around after patient handover, catching up with the patients, I saw a registered nurse working alongside one of the nursing students who was giving out medications. What I saw captured my interest because as I watched I could hear them in discussion about the action of medications and implications of them in relation to the patient's diagnosis. When I asked about what the registered nurse was doing the nurse explained to me that the registered nurse I had pointed out was a clinical teacher from the school of nursing, who from time to time came to the ward to supervise student learning about medication management and new patient procedures. I

realised that this time spent with the students did not align with class room time as it had during my training. This was a special program to assist students at any time that they needed to have some guidance with medications or needed to have specific procedures observed so that they could be signed off as competent to do that procedure alone. My immediate reaction was to think how lucky the students were to have this kind of support for their learning.

As well as missing this support in my training, in all my previous roles I had not been encouraged to talk about the medications to anyone who could help me to learn about their action and impact on the patient. Soon after this I made myself known to the clinical teacher and asked her where I could get some further information about the medications. She directed me to the pharmacology book Mims, a small book that was hidden away at the bottom of the medication trolley. She informed me that information about most of the medications that were in use could be found in this book.

> *I can still remember smiling and effusively thanking her for this wonderful piece of information. The Mims was never away from my sight when I gave out mediations in the future.*

Because my husband was often relocated due to his work for a government department my work life was also transitory. I was never employed in one place long enough to take up a permanent position. I did seek out employment each time we moved and consequently had many interesting new experiences. I always looked for new ways of improving my knowledge. I was pleased to realise that later, when I left the organisation in 1975 and we moved back to Melbourne, that I had been fortunate to see and learn about so much and that I was gaining some confidence as a consequence.

I explained to Margaret, as I told her about the new things I had learnt during my travels including the *Mims* and *Birds* respirator and how to care for a patient on a cardiac monitor, that it was at this time that I had also learnt about the clinical teacher role. I told her how the idea of clinical teaching had remained at the back of my mind because it looked to me to be a great innovation for teaching nursing students. I told Margaret that I believed that my training would have been much better if I had been given similar guidance when I was a student.

> *While I was employed at the hospital and learnt about these new innovations I also took every opportunity I could to teach students what I knew, especially when I was in the operating theatre where I felt most comfortable.*

My interest in teaching did not go unnoticed because the DON and Superintendent of Nursing of the hospital acknowledged my willingness to assist with student training in the reference which she wrote for me after a year of working in that hospital as trained staff (see Figure 5.1).

Figure 5.1: Reference letter of 7th March 1975

> I have found Mrs Siegloff to be co-operative and reliable and willing to assist with the training of the Student Nurses.

Source: Personal Archive

A TEACHING ROLE FOR ME?

The vision of some of the members of the nursing profession to change the way in which nurses were educated was a continuing aspect of my conversations with Margaret during my first months of employment at VGH. She made a point of telling me about how the college program was structured, explaining that these students had full student status and that teaching was expected to be undertaken by experts in their field including scientists, bio-scientists and other specialists in behavioural and human sciences as well as experienced nurse educators. She told me that there

was a goal to have nurses attain nursing education qualifications and for them to be the teachers of nursing theory and practice. This meant that, while many of the specialists such as the scientists who would do the teaching already had a tertiary qualification, many nurses would need to gain tertiary qualifications to be able to work in a college-based nursing diploma program. Margaret was enthusiastic about the future need for a coterie of nurse educators capable of teaching in the new nursing courses in the colleges. She was confident that the current unqualified nurse tutors would be able to do the course that had recently been developed in CAEs. In an aside, which hardly registered at the time, she suggested that this may be where my future lay, especially given my interest in clinical teaching.

At some point in our discussions Margaret showed me the Journal of Australasian Nursing. In her opinion this journal was essential reading, especially the previous year, the December edition of 1976. I sought out the journal in the small hospital library. I was interested to see that it contained many articles about the new pilot college program that had commenced in that state in 1975. After reading it I asked Margaret about the College of Nursing Australia Diploma of Education which I knew that the principal tutor sister of my training school had completed when I had been training. She explained that the College of Nursing Australia would not be able sustain the number of positions required to meet the expected needs of college education for student nurses envisaged for the future. She went on to tell me that a new Diploma of Nursing Education was being offered in the local CAE. She explained also that the reason that she as a clinical teacher was running the orientation program, when it was usually run by in-service education, was because the current in-service educator and the principal nurse educator of the hospital school of nursing were currently undertaking a new course being run at the college. Durdin (1991, p. 208), who was involved with this course from its inception, explained:

> In South Australia a Diploma of Teaching (Nurse Education) had been established in 1975 in the Adelaide Teachers College. The program moved to Sturt College of Advanced Education in 1976 and joined the rest of the nursing programs being offered in the higher education sector.

Because I had shown an interest in clinical teaching Margaret told me about the clinical teachers who were allocated to the wards of the VGH as support for students and registered nursing staff education and development. I had so much to remember about what I had learnt from our many discussions and a lot to reflect on in relation to the changing nursing roles. After absorbing so much about the profession of which I had previously been unaware Margaret stunned me again. She suggested that in the future I might be interested in doing some continuing education.

> *Even though I was excited to be working at VGH and to have the potential to be involved in these significant activities I was not convinced about my capacity to do the study required to become a nurse educator because I had only finished year ten at school and it had been ten years since I had studied. Also, it would be a giant leap for me, especially because I didn't believe girls like me could get a tertiary education, especially as no one in my family had ever gone to college or university. The prospect of study did not fill me with confidence. It took some time to absorb what my mentor had been explaining to me. Also given that my interest was in teaching on the wards as a clinical teacher I couldn't understand why I would need to have a teaching qualification to do this work. However, I was in a place where education and professional development were an expectation and actively encouraged and this expectation infiltrated my subconscious.*

Consequently, I went home one evening full of ideas to talk over with my husband. I was bursting with thoughts about what my future could be, especially if we were going to stay in Adelaide. I told him how Margaret had been encouraging me to do the first-year Registered Nurse Course that was offered by the VGH to registered nurses who had recently graduated from the hospital-

based course. He, like me, was confused because I had graduated ten years previously, so I was not a first-year registered nurse. I explained to him that Margaret had assured me that it could be a way for me to do some study for the first time since graduation and to see how interested I was in learning and whether I could cope. Previously I had told him about being interested in clinical teaching, which was an idea that had been reignited since taking up the position at VGH. I shared what I had learnt from Margaret during our many conversations and explained that I would need to think about doing a nurse education qualification if I wanted to have an official teaching role, including clinical teaching. It would also be a good way to show the DON that I was interested in learning, especially if I eventually decided to pursue a teaching career. Also, secretly I wondered if I would be able to fill some of the gaps that I had realised were very evident in my knowledge.

> *By the end of what turned out to be many conversations with my husband he was supporting the idea that I should take all the opportunities I could to learn, even though we might again move. In the meantime, I should do what I could to improve my opportunities. He encouraged me to do the first-year Registered Nurse course recalling that we both knew that I would always want to work as a registered nurse wherever we went, and this qualification could be an advantage for me.*

I'm a student again

I commenced the first-year Registered Nurse course later in 1977 while still working on the wards. The program included study days of one day a month and a clinical rotation into three different wards of the hospital over the twelve-month period of the program. Each of my student colleagues was a new graduate of the program offered at VGH. I enjoyed learning with and from them as much as from the tutors of the program. We were taught about the Nursing Process and Nursing History taking, hospital budgeting, introductory research techniques, communication skills, leadership and management and learnt some teaching skills. The assessments during the

course included doing a teaching session for the class and undertaking a small research study of the literature for our final assignment. I learnt quickly that this course had been designed to assist the graduates to transition from being a student nurse to the registered nurse's role with all its responsibilities. Although I had graduated ten years previously this course gave me the first opportunity to spend time thinking or talking about the registered nurse's role and responsibilities.

> *The approach I took to learning changed significantly when I was doing this course, it was so unlike the teaching I had experienced as a trainee nurse. I was being encouraged to think and ask questions. I was also using nursing articles from nursing journals and other library resources to read from and engaging in classroom discussion for the first time as a nurse and student. I was also being guided by the nurse educator to read more widely about what was happening in the profession. For the first time I was expanding my knowledge and learning, and I was excited about potential career advancement.*

During this time, I also took the opportunity to watch the educator when she ran the classes - she was open to conversation and ideas. She also invited guest lecturers to speak to the class. Among them was the hospital pharmacist who talked to us about new approaches to medication management, especially pain control. My only previous education about pharmacy had been the Materia Medica lectures that the tutor had read from the text book during my training. The pharmacist's knowledge encouraged me to look more closely at the available information about the medications that we were administering on the wards. I sat in class initially just absorbing my environment and feeling excited to be learning again.

My first ever essay

During my travels I had seen the introduction of new urine testing approaches using reagent strips. When I had learnt about urine testing during my training I was taught to test for protein by boiling the urine, putting a sample of the urine in a test tube and holding the test tube over an open flame to enable the urine to boil for one minute. The result could be a clouding of the urine and the nurse would do a set of tests to determine if there was protein in the urine and identify the amount that had accumulated in the urine sample (Doherty, Sirl & Ring 1963, pp. 126-33). As well as this urine test I was also taught to test for sugar in the urine by using Benedict's solution (Hills 1964-7 Scrapbook).

While I had been working on the ward at VGH earlier that year a sales person from a company that distributed urine testing reagent strips and tablets came to the ward to introduce the charge sister to some of the new reagent urine testing strips his company was now supplying. I spoke to him at length and he gave me a pamphlet that introduced the various approaches to urine testing including the new reagent strips. These new reagent strips could be used to identify protein, sugar and blood in the urine thereby making urine testing a simpler activity than in the past. At one point in the brochure it was pointed out that if the test was not done correctly a false positive test result may occur. This new information intrigued me and set me on the path to learning more about urine testing. Consequently, I used this topic for my final research assignment.

Learning about the history of urine testing and the underlying science of the contemporary, and at that time new, approaches to urine testing using reagent strips was an enlightening activity. This experience made me interested in wanting to know more about what underpinned nursing clinical practices. I wrote a short report from my findings.

This was the first time since leaving school that I had written anything of any length other than letters. Most of what I had written since school was taken directly from the blackboard. I had a difficult time putting the words down on paper and continued with this difficulty for many years until I took advice from my tutors at college. At the completion of this course I attended a special graduation ceremony that was held in the hospital hall, where I proudly collected the certificate 'Ward Management for Nurses'.

HOSPITAL-BASED TEACHER

FIRST STEPS TO TEACHING

I was contacted by the DON, who had now returned to the hospital after completing her master's program, one Friday afternoon in 1978 after I had completed the first-year Registered Nurse Course. She started the conversation in the way in which she always did, calling me '*Siegloff*'. She then proceeded to tell me that she had heard that I was interested in becoming a clinical teacher. After I agreed that I was interested she told me about her plan for me to become a clinical teacher. However, as she went on I realised that there was more to what she wanted me to do than what I had expected at the beginning of the conversation. She informed me that she was going to include me on the clinical teaching roster to work in the medical ward in three months' time, but in the mean-time she wanted me to work in the school of nursing. She needed extra tutors to work in the school because there was a shortage of nurse tutors in the hospital because of the two who were on study leave.

I was amazed that my wish was going to come true, and without me even having to apply for the role. As I left her office I was smiling and resisted shouting about my excitement. I felt a lot like I had on the day on which I entered Matron's office wearing a veil for the first time. I thought that I was on the verge of something very exciting and new. I realised that I was now in

the position because my husband and I had agreed that we would be staying in Adelaide, to plan for a future career in nursing rather then moving from town to town and job to job. I couldn't believe that I was to become a clinical teacher, literally overnight. So much had happened to my career direction in less than two years. I realised that Margaret's prediction had been right because I had shown an interest in clinical teaching and completed the first-year Registered Nurse Course. This had worked in my favour. The DON told me to report to the acting principal nurse educator on the following Monday morning. Unfortunately, Margaret had retired by this time and returned to her original home in Sydney. I never saw her again and was never able to thank her for her timely and caring advice.

There was a new PTS group commencing in the school on the following Monday and I was required to teach them and to teach some of the lectures to the third-year students who were commencing their finals revision study block that same week. I spent a very long weekend being somewhat excited yet apprehensive. I had been a registered nurse for eleven years and for the first time since finishing my first position as a new registered nurse in the operating theatre in that New South Wales hospital in 1967 I was being asked to contribute officially to the teaching of nursing students. I had a sense of belonging and a sense of direction for the future.

Over that weekend I thought about how I was going to be very challenged in this new role. While I was interested in teaching I was only interested at that time in clinical teaching. I believed that my knowledge was limited to teaching about patient care on the wards, but since doing the first-year Registered Nurse course I had become attracted to the idea of the In-service Educator position.

As I set about preparing the lecture sessions for the following week I knew that I still had a lot to learn, especially about the changes to science and technology in health and human biology and their impact on nursing practice. I had not opened an Anatomy and Physiology text book since the second year of my initial training. I knew that I would have a lot to study, especially if I was going to be an adequate teacher in the school. This was reinforced for me when I looked at the text book to see what the current information was about the cell, which was to be one of my first lectures to the new students. On that day I learnt for the first time about the Krebs cycle and DNA. I had heard of the DNA but not the Krebs cycle even though the Krebs cycle had been discovered in 1937. It was not mentioned in the Anatomy and Physiology text book from my training and neither was DNA.

The cell structures that I had written about in my notes as a student only included a Cellular Membrane, Nucleus and Mitochondria. (Hills 1964-7 Scrapbook). This was only the first of many changes advancing knowledge of the body that had occurred since I did my training.

> *As I prepared each of the lessons I realised that I needed to keep up the reading because I would probably be only one step ahead of the students, but I was up for the challenge.*
>
> *I was both excited and apprehensive about my future role however I could see education as part of my future and was grateful for the opportunity.*

DEVELOPING A TEACHING PHILOSOPHY

My concerns about being one step ahead of the students did play out when I first started to teach in the VGH school of nursing. In the first lecture I was required to teach about the bones of the skull to the small new PTS group. This should not have been too much of a challenge as the anatomy was very straight forward. I spent time writing the lecture and traced a picture of the bones of the skull onto a Roneo stencil and duplicated pictures on the Roneo duplicator, resulting in a purple coloured drawing of the skull. These pictures were used as a handout for the students.

I then produced an overhead transparency by tracing the same picture with overhead pens onto the overhead film. This method of teaching anatomy was very common at the time. Over time I produced similar handouts of the heart, kidneys and lungs for the first-year students in the PTS so that they could label them and learn in preparation for their examinations. Making the teaching aids introduced me to the new skills that were required by a nurse tutor at that time.

> *Even now I remember with great clarity how I felt on that day when giving my first lecture in front of a class.*

I walked down the corridor from my office to the classroom. I entered the room. It was a large open space with tables and chairs situated in rows across the room. There was a large blackboard on the wall at the front of the room and a white projector screen attached above the blackboard which could be pulled down over the blackboard to show movies or onto which to project the overhead films. On this day I was going to use the overhead projector, so I took a little time to set it up so that the projections were not blurred and would be able to be seen by all the students sitting in the room.

I said '*Good Morning*' to the class and told the students my name. '*I am Sister Lesley Siegloff*', I announced as I passed handouts to the students. I asked them their names and told them that at the end of this session I wanted them to be able to label the bones of the skull in the diagram on the handout, so that they could use it for future reference. As I said this I sat down because I felt a little unsteady, and my knees knocked!

After this first lecture I had many new experiences learning about how to teach and what to teach from the other tutors in the school. With each new lecture I gave I realised that often I would find myself not only teaching the students, but I was also learning at the same time. One outstanding example was when I gave a lecture to the third-year students when I substituted for one of the

other tutor sisters who was off sick. I was asked to give a lecture on the function of the kidney to these third-year students who were doing their final examination revision study block.

> *I was more than anxious when I prepared that lecture however I prepared it and delivered it to the class knowing that I was probably less than one step ahead of them, or even that they might be half a step ahead of me because they had previously had classes on the subject.*

I had prepared the lecture the night before. During this early stage of teaching I spent most of my evenings poring over the text book so that I would be ready for the lecture on the following day. What I wasn't prepared for were questions from the students. On that day I was standing at the front of the third-year finals revision class. I was reading from my notes when one of the students asked me a question about the role of the nephron. I turned to the backboard and, taking a piece of chalk, began to draw the nephron and as I drew I talked the students and myself through the stages of filtration of urine. As I came to the Loop of Henle I stopped drawing and thought to myself '*oh, that's how it works*!', and after a short pause continued to draw.

> *I had an epiphany that day. I recognised that to be effective as a teacher I needed to have a greater depth of knowledge and to be open to discussion about the topic. This meant researching each subject widely and endeavouring to find interesting resources for the students. Also, although it had never been my experience in the classroom as a trainee, I realised that the students may also have knowledge that they could share. This came from my experience of working with many students in the wards, some of whom had, unlike me, studied biology in year twelve. During this first stage of my journey as an educator it also became clear that the students were disadvantaged when they were being taught by teachers like myself who had very little depth of understanding of the subject.*

After this event I sought out the Principal Nurse Educator and asked her if there was another tutor who might be better equipped to teach the physiology subjects for the final's revision sessions.

My time in this school coincided with the beginning of nurses taking responsibility for the nursing curriculum in South Australia. The nursing school of this organisation was not dissimilar to the school where I had done my training. In 1970 an amendment had been made to the regulations under the Nurses Act which resulted in major changes to the curriculum, including increasing the hours to 1000. Durdin (1991, p. 191) explained that the changes made in the regulations '... did not specify the topics taught but the Nurses Board provided guidelines for the staff in schools of nursing.' This enabled the nurse educators to develop their own programs so that each school approached their program differently. Each school, however, submitted its program to the Education Committee of the Nurses Board for approval prior to implementation.

After my experience the Principal Nurse Educator selected the other registered nurse who had also been recently seconded to the school. She was a first-year registered nurse who had studied human biology prior to doing her student nursing program. She, unlike me, was not one step only ahead of the students. I was then allocated to teach about nursing practice and the professional role of the nurse, both subjects for which I still needed to research extensively to ensure that my information was accurate and up to date, but I felt much more confident in doing so.

> *I learnt a lot from my experience during the early days as a tutor sister, especially how to study as well as to teach the students of nursing. I also learnt that I would be better served not to just use the information from the same text books as the students were using but to look more widely for information for my lectures. I often reflected on the experience of reading the literature about urine testing for my assignment for the first-year registered nurse course*

and recognised that there was more to learn about than what was on offer in our text books.

The first experience of teaching helped me to realise that I was also very interested in the idea of continuing to learn through a formal study program. It seemed much better than just learning on the job.

Although I didn't feel well equipped I sat the mature aged entrance examination, applied for, and received a scholarship from the government department to do the Diploma of Teaching (Nurse Education) and was accepted into the course that commenced in 1979.

This course was run in the same facility as the pre-registration nursing diploma. At this time there were other nurses who were interested in extending their knowledge and were enrolling in other college-based nursing courses. Some chose to do the Community Health course and others did the Conversion course, a course designed for hospital educated registered nurses to convert their qualification to a Diploma of Nursing or similar, which had been introduced in 1976. This course '... led to the award of diploma for nurses who were already registered nurses' (Durdin 1991, p. 196). I attended some classes with these students when I was doing my Diploma of Teaching (Nurse Education).

LEARNING TO BE A COLLEGE STUDENT

When I first went to college I was confronted for the first time with a requirement to learn to write in an academic manner. When I was doing the first-year Registered Nurse course I had learnt some rudimentary skills about the use of resources and literature to support what I was writing. I realised very early in the course that I did not have sufficient knowledge of the rudiments of academic writing. I also realised that I would need to significantly develop my writing skills. I learnt quickly because many of our assignments were in the form of written work, including essays.

On the first day in college we were shown the library. I stood in wonder looking around the library at all its books and resources. Our first activity was to learn how to use the library index, the one most used by us being Medline. We were shown a large manual that had hundreds of pages of what constituted an index of journals, authors and research related topics. We were taught how to search this index by hand and how to find the catalogue number of the article in a journal or book, then how to locate it on the library bookshelves. I spent many hours in the ensuing months and years in that library and soon was able to identify where particular topics of interest to me where stored on the shelves. Of course, this exercise prepared us to effectively use the library extensively during our studies.

The subjects that I undertook in the first year of the Diploma of Teaching (Nurse Education) as a part time student were: Nursing and Nurse Education; Interpersonal skills and Group Processes; Human Development; Introduction to Sociology and Human Biology as well as field experience. I did my field experience in the preregistration nursing program that was being run by that college and was fortunate to have the registered nurse academic, who had been involved in writing the first curriculum for the program, as my academic facilitator. She later became an important figure in my career. Over the years following this experience I have been pleased and privileged to be able to work more closely with this amazing nurse leader in a professional capacity and as a member of a professional nursing organisation where nurse leaders came together to work to improve nursing and nursing education conditions. I watched her with interest and great respect when I was in her classroom and when she was supervising the students in the clinical venue. I learnt a great deal from her about the dignity of good teaching and professional leadership.

I enjoyed the experience of learning about the subjects that were new to me, especially those relating to the profession of nursing and to the social and behavioural sciences. I am not sure whether it was a self-fulfilling prophesy, but I failed my first attempt at the human biology

examination in first-year. However, I was given a supplementary assessment and was not required to do another examination. In recognition that I was doing this subject to teach I was asked to put together three lectures, one on Acid Base Balance, the second on the double helix and the third on respiration. I studied solidly over the Christmas break and developed three posters, drawing the information I was to teach onto three pieces of A1 drawing card. I then presented for the supplementary examination, gave the lectures to the Biology lecturer and passed the topic.

While this result was important for me to complete the diploma successfully I again realised that science related subjects would not be among the subjects that I would be offering to teach in the future. I was going to be happy to leave it to those more expert than I. I remember asking one of the educators on the program why it was necessary for us to do the human biology subjects if we were not going to teach them. Her explanation was not very satisfactory for me because she believed that we needed to be able to teach everything a nurse needed to know. Later I reflected on what she had said and, while I didn't agree with her, I realised that this first course was being watched closely by many people and agencies and that there would be some expectation for future nurse educators to have similar knowledge to that of their graduates. The course opened my eyes to the possibilities for nurses to learn and grow and, unlike as in the past, to make a positive contribution to decision making for patient care.

In most of the subjects that I undertook in the Diploma of Teaching I was required to read widely and to study for examinations, and to write either short statements answering a question set by the lecturer or a more extensive essay. I knew even prior to being accepted into the course that, as well as not being a strong writer, I also had little experience of reading nursing journals. I worked hard to build my reading and essay writing skills. I searched endlessly in the library databases for the articles about the topic of the assignments we were set. I seemed to spend many hours in the library searching and then trying to find the article or text book that I needed. I

would then sit down in a quiet corner of the library, studying and reading and writing out the gems of information that I found there. I was in heaven. I loved the quietness of that place among the shelves, surrounded by those books and journals. I, like many of my colleagues, became quite well known in the library, especially on the weekends in the first year when I had my days off from work at the hospital, and more frequently in the second year when I attended college full time.

After pulling together my resources and notes I would return home to my family and in the evening, after the children were in bed, I would take out my typewriter and put it on the dining room table and start the process of writing. Fortunately, I had some typing skills remembered from my high school days. However, there were often many typographical errors on the page and a great deal of time was taken up with discarding a messy page and starting a new clean page when too much whiteout had been used to try to cover the mistakes. During this time, I learnt the art of literally cutting and pasting. After typing my first draft I would sit on the lounge room floor with the typed pages beside me. I would then proceed to read and look at the logic and flow of the paper, cutting pieces out with scissors and placing the pieces in order on the floor in front of me, adding words of connection by hand as I went. When I thought that I had all the words and pieces in order I would paste them together with pieces of sticking tape and return to my typewriter with many long sheets of paper ready to start typing again. This took many hours of time and I learnt early in my course that I had to be well organised if I was going to meet the assignment deadlines. Even with all the reading and writing I was sometimes disappointed with the results for what I believed had been a well thought out essay. However, I appreciated the comprehensive written notes I received from the lecturers who were very generous in their feedback.

Gradually my thinking, analysing and writing skills improved from what had been minimal competence at the beginning of the course. Although I struggled with the human biology subjects that took up a great deal of my time, I became particularly interested in those subjects in which

we discussed the politics, history and philosophy of nursing and nurse education, and other subjects that were very new to me such as nursing research, sociology, human behaviour and subjects with a focus on curriculum development and teaching and learning. Gray (1979) argued that it was important for nurses to take a stronger leadership role in research than had been evident up until that time. Her position was based on her belief that nurses as members of the profession and the primary deliverers of patient care were in the best position to answer research questions about nursing.

> *Introduction to research was particularly interesting because besides showing us how to search and read the literature I was also introduced to computers. The lecturer taught us how to set up a simple scientific research project, to develop hypotheses, to develop questionnaires, and to draw up a sheet of paper on which to transcribe the data and to do some rudimentary data analysis. That seemed all very interesting to me and my imagination was really captured by the idea that sometime soon, if we wanted to do research ourselves, we may be able to use computers to assist us to analyse the data.*

During our research topic we spent time practicing on the computer entering data as we had been shown and watching the results emerge as if by magic. My colleagues and I wondered if we would be lucky enough to be able to access such resources in our future. However, we did have some access as students to the college mainframe. Some of us took advantage of practicing further. We would book time on the computer in the college computer laboratory so that we could practice what we had been taught.

Personal computers were rare at that time and it was not until 1985 that I bought my first computer, which was ostensibly a word processor. However, once I had it my writing process changed, and I no longer had to spend hours manually cutting and pasting my papers.

CLINICAL TEACHING ROLE

STUDENTS - RELEASED FROM WARD CLEANING TASKS

After the three-month period of teaching in the classroom I took up the role of clinical teacher of the medical wards as the DON had directed. I was both student and teacher undertaking the clinical teaching role and studying part time in the college doing the Diploma of Teaching (Nurse Education). When I was working on the wards I worked closely with the students of the hospital-based program as part of my daily routine. This experience reinforced for me the differences between the expectations being placed on the nursing students of that time in comparison to what had occurred during my training.

The students of the hospital program were still members of the hospital staff and were rostered to work in the wards and departments when they were not rostered to the classroom. All lectures were offered in a block so, unlike my experience as a trainee nurse, these nursing students did not need to attend class when rostered off duty. When on duty the ward cleaning was no longer the domain of the student. Their focus was on learning and doing patient care. Cleaning pans and the pan room, ward dusting and post discharge bed cleaning was now the responsibility of cleaning staff who were employed specifically to do these tasks. The bed linen was now delivered to the ward on a linen trolley and left in the corridor so that the linen was easily accessible to the nurses. No extra handling or refolding of the linen was necessary in this situation. However, the students were still required to clean up after themselves and to leave the pan room tidy. To ensure that they were aware of what was happening on the wards before they went off duty at the end of each shift the students were required to ensure that the patients' environment was tidy, that required care had been completed and that the patients were comfortable.

It was at that time that I consciously recognised that the hospital students were no longer handing out meals because pantry staff were employed to deliver patient meals and drinks and to clean

away dishes. In this hospital the DON held nursing staff meetings and on one occasion I recall her telling us about the move being made by the Royal Australian Nursing Federation, of which both she and I were members, to develop a policy on non-nursing duties because they believed that there were still more duties that nurses should discard. It was not until 1991 that the official report on this work was released. In the rationale on non-nursing duties in South Australia Beecken (1990, p. 1) elaborated:

> Both the ANF (1985) and the SA Health Commission (1986) have undertaken studies into non-nursing work which indicated that nurses, often routinely at various other times, undertake duties which are not 'nursing duties' and should be reasonably undertaken by other categories of health worker already employed.

This report goes on to identify the following 'non-nursing' duties:

> Cleaning barouches and beds, often lockers and cots. Transport of patients. Movement of beds to make more room available. Emptying linen bags, Errands to and from pharmacy, pathology etc, weekend cleaning, in some areas distribution and collection of jugs.

The report by Beecken (1990, pp. 1-2) further identified that the duties were often spread over 24 hours and '... could make up to between 2-8 hours of work'. This work was the domain of the nursing students of the hospital-based program for many years, and which slowly disappeared as students were no longer employed in hospitals. Durdin (1991, p. 226) explained that the aim of the non-nursing duties policy:

> … was to provide a safe environment for patients and to ensure that the nurse, whose primary concern was patient care, was not prevented from providing this care through preoccupation with other responsibilities.

New categories of hospital staff were created to pick up these duties.

According to Durdin (1991, p. 226) 'The policy statement also drew attention to the need to collaborate with representatives of other hospital workers to define areas of responsibility', going on to acknowledge that these changes caused concerns for some nurses because '... as others took over particular aspects of patient care, nurses felt that their own role was diminishing.' We nurses

were the main contributors to the ward work that included in patient care, and cleaning took up many hours of my time when I was a student.

The introduction of non-nursing employees to perform non-nursing duties was not the only reason for changes in practice. From the late 1970s I began to see disposable equipment, including syringes, being introduced into the wards. I was one who was relieved to see these new innovations because students no longer needed to spend hours of time washing up the equipment that had been used or making up dressings and dressing packs. Because students and all nurses, including myself, were released from these mundane and repetitive tasks I realised that I could now spend more time with the students, observing them doing direct patient care and assisting them with more focused clinical learning on the wards.

ENCOURGING STUDENTS TO TALK TO PATIENTS

It was a pleasure to realise that my concern during my training about being discouraged from talking to patients was no longer considered appropriate. As well as being taught to talk to the patients on the ward, communication studies were also being included in the hospital-based nursing course classrooms by 1977. Students were also being taught about the importance of communication as a way of improving patient experiences and outcomes in the pilot college program.

According to Durdin (1991, p.96):

> Among the strengths of the programme were studies in physical and biological sciences and behavioural sciences that continued throughout the courses, underpinning the clinical nursing studies and practice.

Sandra Finlayson was. In an article in the *Australasian Nurses Journal* Finlayson (1976, pp. 42-3) a lecturer in nursing involved in teaching the undergraduate nursing students at the college ,explained the changing approach to nursing education, which was evident in the new college

curriculum She wrote(Finlayson 1976, pp. 42-3) 'In recent years it has been recognised and accepted by health educators that the social and behavioural sciences need to be incorporated into the curriculum of nursing students.' Finlayson (1976, pp. 42-3) attributed this change to curriculum content:

> … occurring as a result of renewed emphasis on the concept of the patient as a whole person, rather than a case of disease. Although this concept of the patient is long established, and generally acknowledged, it is a concept not often carried into practice. This component of the Nursing Diploma course aims to provide not only knowledge and practice to optimise patient care, but also seeks to provide personal growth experiences of an emotional and intellectual nature for the nurse. The nurse can develop the ability to detect significant clues which may have a bearing on the patients' responses. In essence this means acting as an emotional detection agent, which is vital if adequate psychological support is to be given, and there is to be liaison and interpretation between doctor and nurse.

The Diploma of Teaching included similar subjects such as learning about effective communication. This ultimately had an impact on the way in which I worked with students. I spent a great deal of my day as a clinical teacher assisting students with patient treatments including pressure area care, wound care and with patient communication and the extensive patient documentation that was becoming an important part of the nurse's role.

I found that the admission of patients was an ideal time to work with the students to get them to think in a comprehensive manner. When a new patient came into the ward either a college student or a hospital-based student would be allocated to undertake the admission assessment and complete the documentation in time to hand this information on to the nursing staff. As a clinical teacher it was my role to supervise the first-year hospital-based students in this activity. I continued to envy the students as well as to celebrate the support that they were receiving on the wards. I could see that they were less reserved about what they were doing than I had been throughout my career. Consequently, when I was supervising the students to undertake practices such as admitting a new patient, I encouraged them to integrate the

information that they had ascertained into the patient history and to document it into the patient care plan. I recalled my experience of doing an admission when I was a trainee and realised that the students who I was supervising, unlike me, were adding to the information available to other health care workers. I found this a very worthwhile role.

During my training, when a patient was admitted my major focus was in writing a half page of information about the patient into the patient records and then ensuring that I gave the patient an admission sponge. During that time no patient history was taken, and neither was there a requirement to develop a patient care plan. Another significant change in the care of patients who had received surgery was that the patients of the 1960s were sponged in bed for some days following surgery. This was like the experience of patients who had suffered a significant medical event and spent long periods of time in bed. By the late 1970s these types of patients were being encouraged to get out of bed much earlier. These patients rarely spent long days in bed and were encouraged to walk around and sit in the patient lounge, which prepared them for an early discharge following surgery or a medical event.

TEACHING OBSERVATION SKILLS

It was common practice for me at the beginning of a shift to walk with a student to the entrance of what are often called, because of their configuration, '*Nightingale*' wards. There were twenty beds in these wards, situated down each side of a long room. I would ask the student '*What do you see nurse?*' I would then instruct the student to look around and to tell me what was happening with the patients. I had come to realise that if I engaged in an active process of observation with the students they were quick to pick up cues about the patients' condition and their environment.

When I did this with the students it was not uncommon to see that some patients were sleeping while others were talking to one another or to visitors. Some patients were comfortable, others

looked uncomfortable with their pillows on the floor or even lying flat in the bed when they should be sitting up, or that their bed needed tidying. The patients were observed on occasions to have an empty water jug or in the male medical ward may have a urinal on the over-bed table. It was also an excellent time to observe patients ambulating or to check their drainage bags or intravenous fluid levels. We would spend some time talking about what each of us had seen and then go about rectifying any issues as we did a round of the patients. I came to recognise that my role of clinical teacher was mainly as a facilitation showing the students by example. This also included demonstrating how to introduce myself to the patients and how to talk to each of them. I would also introduce the student to the patient and guide the conversation toward how the patient was feeling.

> *Taking time like this with the students was one of my favourite activities of the day. It gave me an opportunity to talk with them, not only about the patients, but also about the importance of the environment on the health of the patients. I found that this was a good time to ask students about the patients and to answer questions while establishing a way for them to routinely think about the whole ward environment as being as important as the individual patient needs. It was also a time to teach about patient care and about managing their workload. I wanted these students to have a better clinical learning experience than mine had been.*

Influencing clinical practice change

As time went by my role as a clinical teacher expanded from primarily teaching students about the fundamentals of nursing to include a responsibility to teach registered nurses when the DON wanted to introduce new approaches to patient care.

At this time, I was a member of both the hospital teaching team and of a special projects team that included the clinical teachers and the hospital nursing special projects officer. The special projects team was called on by the DON to be at the vanguard of several changes she was interested in implementing in the hospital. This included the introduction of quality assurance and the development of standards for the hospital patient documentation system and a concurrent and retrospective patient care auditing system. She was also instrumental in having this team introduce new practices to the nursing staff that were designed to improve pressure area care as well as a new patient allocation system called primary nursing. I was involved in developing and writing the various nursing standards and teaching strategies designed to implement the new initiatives, both in the classroom and on the wards.

Introducing the evidence

One afternoon the DON called me to her office. She told me that she had asked the nursing supervisors to distribute a copy of an article published in a British nursing journal to each of the ward charge nurses[2]. The article introduced information about recent research into pressure area care of bedbound and inactive patients. She also explained that she wanted me and the other clinical teachers to work with the nursing staff on each ward to introduce this information about the prevention of pressure area sores.

> *This article caused me to reflect on what I had learnt about pressure area care when I was a trainee and how this practice had continued through the years until this article came to light.*

[2] I have not found this article after significant searching of library data bases. I believe it was published in either the Nursing Standard or Nursing Mirror published in Britain in the late 1970's.

As a trainee I had learnt to do pressure area care every two to four hours on patients who were bedbound. This included vigorously rubbing the patient's back using methylated spirits. Gray (1979), writing about the importance of research in nursing introduced information about how it had recently been influencing changes in nursing practice. In an example she described how some nursing changes had occurred in pressure area care.

Gray (1970, p.41) wrote:

> To use the example of pressure care, it is evident that changes have occurred in this nursing procedure; for example, we no longer use methylated spirits and some of our other pet remedies that existed some years ago. … There is evidence in the literature that research has been conducted into this aspect of care.

When patients remained in bed for extended periods of time we worked hard to ensure that there were no wrinkles in the bed, that the bed was dry, that the patient did not experience pressure on their buttocks and that they did not slide down the bed! Sliding down the bed would cause friction and reddening of the buttocks often occurred. What I did not understand at that time was that we nurses were also causing damaging friction which resulted in reddening and a breakdown of the skin over the coccyx because of the vigorous rubbing when doing back care. I, like most of my peers, enjoyed doing the backrubs. It was a challenge to see which nurse could give the patient the best and strongest back rub.

The patients would often make comparisons between the various nurses' skill. The harder the nurses rubbed the patients back the more the patients wanted, and they often played one nurse off against the other. It was no surprise that myself and my fellow students were always wondering why we continually seemed to be losing the battle to prevent patients from getting a large pressure sore known as a decubitus ulcer.

Until contemporary nursing practice changed the practice of pressure area care in the late 1970s because of the article that the DON had circulated, patients had continued to suffer from these

pressure sores. No matter how hard nurses worked at trying to prevent them many of our patients, especially the elderly, still experienced very large pressure sores over their coccyx and sometime on their heels. Ulcers often held slough and pus and were often very deep and at times so deep that that coccyx was evident in the wound. I heard a doctor say once that he thought that the patient had a cavity the size of a dinner plate over the coccyx that was spreading over the cheeks of the buttocks.

We were required to do the dressings of these wounds, cleaning and packing them with gauze that held a solution that was supposed to assist in removing the slough, which was called EUSOL (Edinburgh University Solution of Lime). The ward often smelled pungently of the EUSOL, which had a smell like Milton, and pus. I rarely saw these wounds heal and some patients died of infections because of these wounds.

The DON's motivation for the change was related to her concern that so many patients had pressure sores that would not heal no matter what we did and that some patients were being discharged with pressure sores. Her motivation for every innovation that was introduced into the nursing division of the hospital was for patients to have the best quality care possible. To ensure that the new approach to pressure care was implemented she sent a directive to the nurses in charge of the wards requiring them to ensure that all nursing staff discontinued the ritual of rubbing patient' lower backs over their coccyx as a form of pressure area prevention. She also instructed me and my fellow clinical teachers to ensure that the patients were moved off their buttocks at least each two to four hours even when they were sitting out in a chair.

She also instructed us to teach all nursing staff to wash and lightly massage the back of the patient rather than to rub vigorously. The research had revealed that continued friction from heavy back rubbing was having a negative effect on the patient's skin condition around the coccyx. The

research message was that the rubbing was causing the muscle under the skin over the coccyx to tear because of the continual rubbing and within days a pressure sore would erupt through the skin.

> *Change of this kind turned the nurses' world upside down; many told me that they felt that they were being accused of causing the pressure sores. I felt very much like my colleagues because I also had been doing pressure area prevention in this way, as I had been taught as a nursing trainee in the 1960s, even though we had always thought we were losing the battle to prevent pressure sores.*

Sometime after the introduction of eliminating the vigorous rubbing of patients' backs it became apparent that the message had not been very clear. What we realised was that the nursing staff had taken the missive of the DON very literally and had even discontinued washing the patients' backs because they believed that they may cause some damage through that rubbing motion.

> *This taught me that it was important to explain to the nurses what the article was saying and to follow up to ensure that they understood the message, that the way in which we vigorously rubbed the patients' lower backs, especially over the coccyx, was causing harm. However, when we washed the patients' backs it did not involve vigorous rubbing and this was an important part of patient care.*

As well as impacting on years of practice this article also had a huge impact on my learning about how research could change the way in which I could practice. Up until that time, other than the small study I did in the first-year Registered Nurse course, I had little experience of nurses doing research that had an impact on the way in which we did nursing care. What I had learnt over the years had mostly been based on traditional practice rather than research.

The change in practice meant that we were being asked to change from what we had always done to something new. Most of the nurses reluctantly did change, but many times I was told that they were uncomfortable about changing a practice that had such a long history, but that they would do as they had been directed to do. Some of the registered nurses also voiced their concerns about the way in which the DON was constantly changing things on the ward. I heard some of them say that they were concerned when she went to a conference because she always seemed to see something new and wanted to try it on return.

As one of the registered nurses who had experiences at a time of similar changes, prior to my taking up that clinical teaching role, I also felt anxious about all the changes. At times it felt like I wasn't knowledgeable enough to follow through on her ideas. However, years later I realised that this DON was trying to guide the nurses toward a new way of thinking and practicing in the new role that was emerging because of a change in duties. However, with all her forward thinking this did meet obstacles that were reflective of the limitations of knowledge and capacity of the nurses working in that organisation.

Even prior to this change the DON worked with my clinical teacher colleagues and myself to introduce primary nursing into the wards. The DON wanted to introduce this new patient allocation system as a way of organising patient care because she believed that it could assist in removing the traditional 'task allocation' of patients. This new way of working could have the effect of engaging registered nurses directly in doing patient care as opposed to their usual role of predominantly overseeing the ward work. Up until this time direct patient care was primarily the responsibility of the students and the enrolled nurses working on the wards. This new approach was designed to ensure that all of the patients' needs were carried out by a primary registered nurse who was to be assisted by a student or enrolled nurse. According to Durdin (1991, p. 220) '…

the DON believed that primary nursing would improve the accountability of the registered nurses for patient care and that the patients would be attended by the most qualified nurses.'

My role and those of the rest of the special projects team was to implement the new system with the nursing staff on the wards. My colleagues and I spent many hours explaining the primary nursing approach to all the hospital nursing staff working on the wards. We experienced a great deal of push-back from the registered nurses who were anxious to tell us that it was not their role to be the primary carer on the ward. In their opinions that was the role of the students or enrolled nurses. Some told me that they believed that their role included oversight of the whole ward and it did not include undertaking basic patient care such as bedmaking, sitting patients out of bed, pressure area care, showering or sponging patients in bed or patient admissions. In their opinion if they did this work the students would not learn. In later years the DON was being interviewed by Durdin (1991, p. 220) at which time she acknowledged that the attitudes of the nurses on the wards '*proved a stumbling block*'. Relatively inexperienced registered nurses found accountability stressful, and after a trial period the practice of primary nursing ceased, with the hope of reintroduction when sufficient experienced nurses were available. The DON was a champion of college-based education and was preparing for a time when the hospital no longer employed nursing students. She often talked to our nursing education team about a time in which she envisaged that the nursing students would come from the college to work in the hospital.

NURSING LEADERS SUPPORT THE CHANGE

DIFFERING EDUCATION APPROACHES CAUSE CONFLICT

The Diploma of Teaching (Nurse Education) was held over one year of part time study (one day per week) followed by one year of full-time study. During the period of my studies in the first year I did so part time and worked the rest of the week as a clinical teacher in the hospital. In the second year I was fortunate to have a scholarship from the hospital that allowed me to be on full pay as a

full-time student. I travelled to college with fellow colleague Pat (pseudonym) from the hospital where we were employed. She had also gained a scholarship.

> *On these drives to and from college we set about solving the problems of our world. These were quite different conversations to the ones that I had previously had as a trainee nurse. Now I was focused on the future of nursing education rather than on how to survive the rules of my training days. Our conversations were based on our concerns about the future of college education if the current attitudes about college education held by many fellow members of the nursing profession continued. We talked about the need for a cohesive nursing position to be held by the profession about the changes if the vision of college education was going to be successful. I was continually expressing my concern to Pat that so many of the nurses with whom we worked believed that the education system shouldn't change. I wondered why they couldn't remember what it was like to be treated more like labour than a student and to practice, not from knowledge, but by religiously adhering to rules and routines.*

We discussed our memories of an environment that lacked the capacity to adequately prepare students for a future in which technological and medical advances were becoming more and more evident and changing the way in which we were nursing. Pat was particularly concerned about the limited amount of science being offered in hospital-based nursing courses. My concern was that, even though the nursing students were no longer doing cleaning duties, they were still primarily workforce rather than students having their learning time prioritised over ward duties.

We talked at length about what we thought was essentially the mythology of hospital-based nursing education, which seemed to revolve around the image of nursing students learning at the feet of the sisters who worked alongside the student while teaching them at the bedside. Although I experienced limited teaching or learning at the bedside during my training, there was

some small reality of this for current students, especially where clinical teachers were available to support the student when they worked on the wards. However, I realised that not all hospital programs offered this important support and even though we clinical teachers were there to help we were not present for the entire shift like the students.

During our discussions we reflected on the discontent that was often evident in the wards in which we worked. The registered nurses and students of the hospital program often complained that the college students seemed to get all the privileges and attention. Durdin (1991, p. 197) wrote about the resistance to the new course that had been evident among the nurses from the outset of the change, stating that there was '... a natural resistance to the new course and its graduates from some nurses who had graduated from the traditional education programmes.'

Even though there was some dissention evident between nurses many nurse leaders, including the DON of the hospital, continued their outward support through lobbying for the future of nursing and their belief in the necessity to move nursing education to the higher education sector, and ultimately the gaining of recognition as a profession. During our conversations in the car Pat and I often expressed surprise that the senior leaders of the profession demonstrated their collegiality with other leaders in hospitals in the state by working together for the changes, but they did not seem to be able to influence many of the nurses they employed to understand their goals. Tensions existed among the staff on the ward and this was very evident to us when we went into the wards.

One of the most positive conversations Pat and I had during our trips to college on these occasions revolved around our being fortunate to be working under a very progressive DON who had supported our application for a scholarship to go to college, who encouraged the nursing staff to read nursing journals and to get involved in new approaches to nursing care. It was encouraging

for us to be a member of her nursing team and to be in South Australia where it was evident that all the directors of nursing of major organisations were supporting the changing approach to nursing education. However, we also recognised as Glass (1992) had, that while the directors of nursing of the major hospitals were very supportive of this change, the nurses at the workface were disgruntled. According to Glass (1992) some registered nurses who worked with the newly registered college graduate nurses believed that these college graduates were not very well prepared for their role.

This attitude was reinforced to Pat and myself when we were frequently confronted by other registered nurses on the staff who complained about the new courses because they didn't see how the students would get a proper nursing educational experience if they were not employed by the hospital like the hospital-based students. These ward registered nurses also often expressed their concern that, even though they had years of experience, they might also need to study in the higher education sector. They didn't want to have to do further education. It seemed to them that this idea of educating nurses in the college would not be successful but that in the mean time they could be disadvantaged because they had a certificate and they thought it was inevitable that the certificate would be phased out and that they would be redundant.

These conversations were grist for the mill in the tea room. They caused confusion among the hospital staff and often resulted in anger toward the college students in the first instance, especially after the first cohort graduated as new registered nurses.

The college students were very aware of the disapproval of their peers and it became a problem for them. This became very evident when the first cohort graduated. I remember meeting with one of the graduates who was trying to blend into the hospital as a first-year registered nurse. To

achieve this, she decided not to wear the nursing badge that she had received from the college at the time of graduation and did not talk about being a college graduate.

The focus of Pat and my roles as nurse educators in the hospital was on ensuring that these graduates had a positive experience when they were being socialised into their registered nurse role in the hospital. What we realised over time was that the criticism of the different educational courses undertaken by the college graduates and the hospital graduates was a cause of conflict. We deduced that this could be attributed to the situation in which they were supervised by hospital educated registered nurses who had little or no understanding of the way in which the college graduates had been educated. These registered nurses were looking for both graduates to be the same.

The resistance to change that we experienced was recognised by Piercy (2002, p. 240), who explained that 'Underlying nurse education reform was the powerful resistance from people in positions of authority both internal and external to nursing. They steadfastly clung to the status quo.'

NURSES MARCH FOR NURSING EDUCATION

As a college student in 1980 I was fortunate to be taught by lecturers who were at the coal face of the discussions and debate about how they wanted nurses to be educated for the future. As a diploma student I became very engaged in the activities relating to the transfer of pre-registration nursing education. Looking back, it would have been difficult not to become involved because of the enthusiasm of the lecturers who were not only our teachers but also in some ways our muse. Effectively we, as students of the college, were in the thick of the movement in South Australia. In the following scenario I share the story of my first engagement in political activities designed to keep pre-registration nursing education in the college.

A CALL TO ARMS

I was sitting in the classroom one day talking to my fellow students about the research topic that we were doing at that time. The lecturer was late, which was unusual, and when she did appear she seemed out of breath and looked anxious. This surprised me because she had up until this time always seemed so self-assured, friendly and very engaging with all of us. After entering the classroom and seeming to collect her thoughts she addressed the class. She explained that a decision had been made by the state government to consolidate teacher education courses in South Australia and because of this the college I was studying at was to close. We were informed by our lecturer that the nursing course would be collateral damage if the college closed. We were all shocked and I quickly realised that our course may also be at risk. She told us that there was to be a focused effort made, by various members of the profession including our lecturers and other nurse leaders involved in professional nursing organisations, to put up a fight to save the college.

On that auspicious day I was asked by the nurse lecturer if I would be prepared to be interviewed by a reporter from a local newspaper, John Kirby, to give a student's perspective about the impact of the potential closure. I agreed, as did one other of my peers. Part of the interview, in which I shared my opinion, was headed: '*Why angry nurses are on the march*' and published in *The Sunday Mail* on 27 July 1980.

I was quoted as saying:

> If I want to remain in nursing education I must have a diploma, Sturt is the only place in this state where you can get one. It wouldn't help us to strike. It would not help our patients. By marching we are standing up to be counted.

In that article there was also a response by one of my peers who was interviewed at the same time, stating that the new students would, 'spend more time on nursing and less on washing bedpans'.

The article advised that students of the college supported the march and the continuation of the programs at Sturt and explained that nurses were responding to the Tertiary Education Authorities call for the closure of Sturt College. It also advised that the nurses of South Australia would be marching in the main streets of Adelaide in protest.

On my return to work after class that week I also spoke to the DON about what we had been discussing at college. She was equally concerned and supported the view of a march in the streets. The DON demonstrated her leadership of nursing in South Australia to the community when she wrote a letter to the editor of the *Adelaide Advertiser* on 5 August 1980 stating:

> On Friday July 25 history was made in Adelaide by 800 nurses who united to demonstrate about the continuing problem facing the profession regarding nursing education. Most of the nurses came from a hospital based program. By their presence they all agree their preparation was not sufficient for nurses today.
>
> I am proud of the solidarity of those nurse who marched, and proud to be one of them. The uninformed or ill-informed members of both Federal and State governments should take a long, hard look again at nursing education. As the 800 nurses shouted on the steps of Parliament House we want the Sax Report accepted and Sturt CAE allowed to continue the excellent nursing programs it has developed, then the South Australian community will get improved nursing care.

There was also an article headed '*Nurses march in protest*' in the *Adelaide Advertiser* of 26 July 1980 which included a picture of the DON and a lecturer from the college leading the march through the streets of Adelaide. The cutting from the newspaper (see Appendix 12) shows them dressed in old fashioned uniforms of nurses of the past and carrying storm lanterns, leading the contingent down the main streets of Adelaide to influence the government about the importance of Sturt College remaining open. Another director of nursing wrote a letter that was headed '*Nursing Needs*' and supported the change in approach to nurse education. In her letter to the editor of the *Adelaide Advertiser* on 6 August 1980, the Director of Nursing of the Royal Adelaide Hospital, P J Spry, stated:

> It is believed by the profession that patients wish to be nursed by nurses legally qualified in the profession.

> Most nurses recognise the deficiencies of their own training in the hospital setting and had hoped for a "better deal" for the nurses for the future - nurses who should be educated in colleges of advanced education with student status.

Both leaders ran nursing organisations that included a hospital school of nursing and, while they continued their commitment to ensuring that the programs offered in their organisations were of a good quality, their missives indicated their belief that things needed to change.

> *I remember being inspired by all the nurses I was walking with and their commitment to the advancement of nursing. I also was proud to be a student of the College and equally proud that I worked for a nurse who was also an inspirational leader.*

The differences in attitude to the way in which nurses were seeking to be educated caused a great deal of tension at the time between nurses and the public. This can be seen from some letters to the editor of the *Adelaide Advertiser* during July and August 1980, which are transcribed below:

> Nurse education in SA,
>
> I wish to protest at Miss PG Deal's criticism of hospital-trained nurses.
>
> I firmly believe that general nurse training belongs to hospitals. Text books cannot replace three years' experience in patient care.
>
> E Robertson, 6/8/80 Adelaide Advertiser.
>
> ....
>
> Nurse Training
>
> The difficulties of the School of Nursing and Nursing Services in providing an appropriate and integrated program for students and safe care for patients have a detrimental effect on the whole nursing care structure and patterns of care.
>
> Kathleen Goodlee Principal Nurse Educator and 11 nurse educators 31/7/80 Adelaide Advertiser.
>
> ....
>
> Nurses Action –2

Nurses believe that unless Federal Cabinet reverses its decision on nursing education the community's high expectations of health care will not be met and that the already high costs of health care will continue to escalate

Rosemary Bryant, Chairman, Professional Development Committee, Royal Australian Nursing Federation (SA Branch) and 210 Committee members. 1/8/80 Adelaide Advertiser.

I must express gratitude to the members of the nursing profession who took to the street to protest against the proposed reduction of already inadequate training received by them.

Adrian Hockley Brompton 1/8/80 Adelaide Advertiser.

....

That bedside devotion v cap and gown (community member against)

A community member concerned that the nurses who were interested in getting a cap and gown and not learning in the hospital were at risk of becoming Jills of all trades and master of none if she supported continuing education in the tertiary colleges.

I see the movement as a demonstration of jealousy of other health care disciplines; nurses should remain at the bedside and NURSE THE PATIENT.

CM Grose Lilydale, Tas 1/8/80.

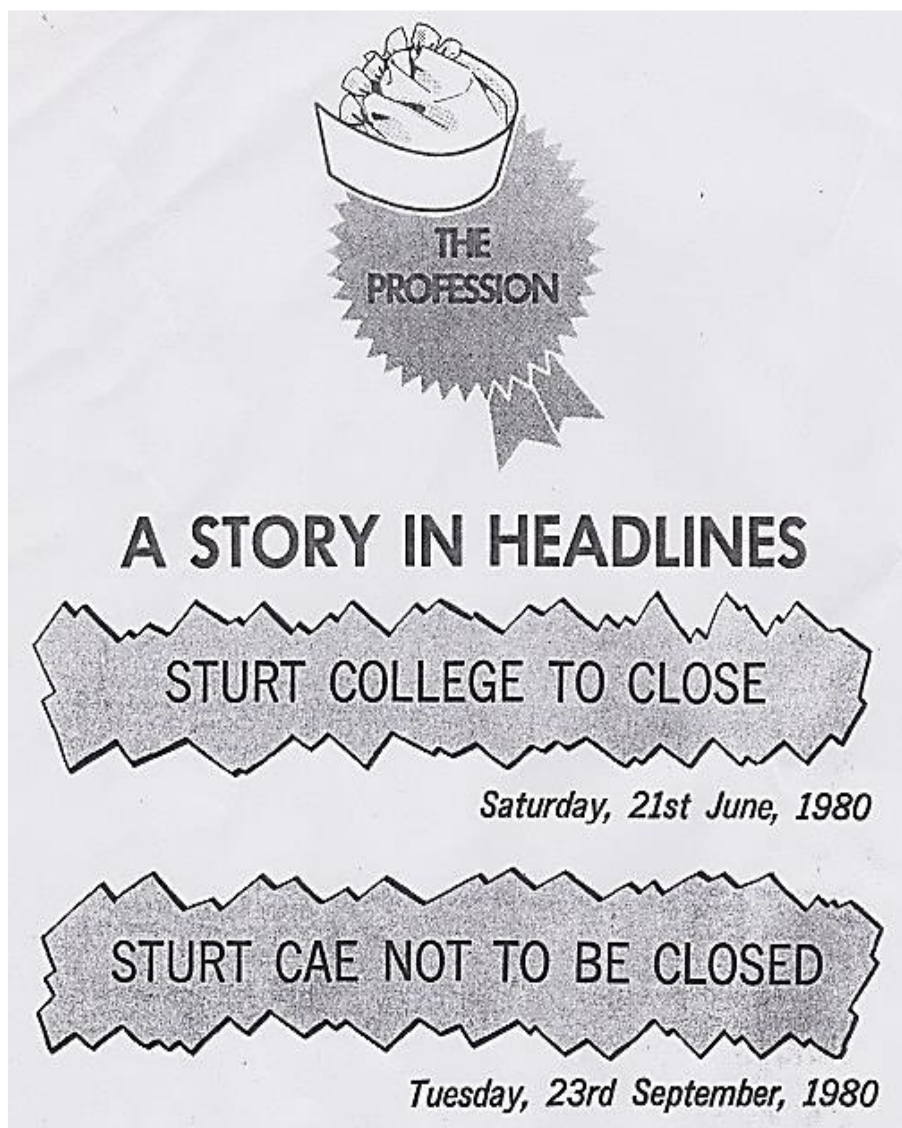
....

As I reflected on these letters when they appeared in the paper that week I realised that nursing had more than one issue to confront - not only where nurses were educated but also how they would be supported when they graduated because, while many of us were supportive, this was not a generally accepted or united view.

I felt like the negative attitudes in these letters demonstrated a lack of understanding about the student nurses' learning environment that had remained generally unchanged for 100 years up to that time.

The lobbying to keep the Sturt program open was successful. In an article in the Australian Nurses' Journal Durdin and Cochrane (1980) congratulated members of the nursing profession for their efforts in causing the government decision to close Sturt College to be reversed. A copy of the joyous headline from this article is shown at Figure 5.2.

Figure 5.2: Australian Nurses' Journal Durdin and Cochrane (1980)



THE PROFESSION

A STORY IN HEADLINES

STURT COLLEGE TO CLOSE

Saturday, 21st June, 1980

STURT CAE NOT TO BE CLOSED

Tuesday, 23rd September, 1980

Source: Durdin & Cochrane (1980, p. 10)

This event had a significant impact on me and I realised that I wanted to continue to be a part of the team that did this work. The strong bond that was demonstrated between our nurse leaders of the professional and industrial organisation leaders galvanised me to also become an active member of professional nursing organisations.

McCoppin and Gardiner (1994, p. 101) in their book *Tradition and Reality, Nursing and Politics in Nursing in Australia* used the voices of nurses to show how nursing in the 1980s had evolved as an accepted voice of policy making, explaining that:

> ….at this time too, nurses mounted what became a successful defence of Sturt CAE (now part of Flinders University) in Adelaide, home of one of the earliest preregistration programs and threatened with closure. This incident enabled South Australian nurses to show that they had become effective political activists.
>
> It was during a Liberal administration in this state that they tried to get rid of Sturt College … In the campaign that followed … we would get people who would phone up the Minister for Health … people who would go to their local MPs with questions, and identify people who were likely to be ambivalent or slightly in our favour, and then feed them masses of information about what the impact on the various [electoral] constituencies was going to be [AP/88]

BURNING THE SAX REPORT

In the early 1980s yet another report about nursing education was initiated by the government of the day and the profession was concerned about a delay in its publication. When the report was eventually released it became known generally in the profession as the Sax Report. The recommendations of the report of this enquiry were slow to be acted upon. The slowness of the government in responding to the recommendations caused a galvanising of members of the profession to lobby for change as they continued to seek a complete transition of pre-registration nursing education to the higher education sector.

The Sax report (1984) identified that the issues evident with nursing education in Australia in 1978 were still relevant in 1984. The authors were concerned that there was no equity in the current

approach to education. There were still many students who were undertaking what was still considered to be an apprenticeship in the hospital-based programs as well as others in the pilot college courses being offered in several states in Australia. A nursing conference was occurring at the time of the release of the report, being held in Adelaide in May 1984 by the College of Nursing, Australia to coincide with International Nurses Week. I attended this conference along with four hundred other nurses from around Australia. When the conference commenced the organisers were hopeful that the report would be released imminently and that it would hold long awaited good news for the profession regarding the future of nursing education in Australia. The hope was that pre-registration nursing would be transferred completely into the higher education sector by the following year. The report was released that week while the conference was still in session. However, the outcome of the report was far from the expectations held by the nurses attending that conference. On the afternoon of the release the attendees of the conference were asked to assemble in the main auditorium of the conference building. The Executive Director of the College spoke to those of us assembled as did several other nurse leaders in attendance. I remember their disappointment at the outcomes after the profession had been working for so long in trying to achieve change. Among the spokespersons was Judy Porter, then the Chief Nurse of South Australia, who shared her concerns as a member of the committee involved in the project that the outcomes reported were not what had been expected.

This was one of the first professional conferences that I attended. It was at the induction event held at this conference that I became a Fellow of the College of Nursing, Australia. I was impressed by the eloquence of the nurse leaders and as McCoppin and Gardner (1994) explained, these nurses succeeded in capturing the concern in the room. After all the people had spoken there was, what appeared to me to be, a call to arms when we were all asked to assemble on the forecourt of the Festival Theatre. There I watched as a copy of the report was placed in a metal dish and

burned. Reporting on the events of the conference ten years later McCoppin and Gardner (1994, p. 111) wrote that the recommendations gave no indication of a transition occurring in the next three years with the consequence that '... the people of Adelaide saw nurses marching in their streets to protest about nursing education for the second time in four years.'

Judy Porter was one of the leaders who walked at the front of the contingent of nurses who marched down the streets of Adelaide to deliver the ashes to the Australian Minister for Health, whose constituency office was in Adelaide. McCoppin and Gardner (1994, p. 111), writing about this incident explained:

> When the nurses at the Adelaide conference heard about the CTEC recommendations on 11 May from the college's executive director, June Cochrane, they were so incensed that they voted overwhelmingly (on Elizabeth Pitmans suggestion) for a symbolic burning of the Sax Report and a march to the office of the Federal Minister for Health. With victory in sight, they were in no mood for last minute prevarication. The Sax Report was out of date, said Judy Porter, and she and Sister Paulina, who had both been members of the original committee, led this unusual public display of senior nursing strength.

This legendary march was different to the previous march that resulted in keeping Sturt open. This was focusing on the transition of pre-registration nursing education across Australia.

> *When I returned to class the week after the march I became engaged in conversations with my fellow students and the lecturers that focused our concern on the fact that some of our colleagues disapproved of the new thinking about the education of nurses. We all felt that we were somehow being thought of as heretics working against nurses rather than for the profession's advancement. For me the college lecturers were very convincing in their arguments that things would change for the better when all nurses were being educated in college programs and eventually the community and our colleagues would see that value. At my core I knew this was true, but I realised that when I went back to the hospital to work when I had finished my Diploma I would encounter a great deal of opposition. However, I felt very happy about the*

backing of the leaders of our profession in the State and that kept me, and my colleagues focused on the goal.

Parkes (1984, p. 177) proposed support for the change in approach to nursing education, that '... hospital-oriented training must give way to more comprehensive health-oriented education.' Parkes (1984, p. 178) explained the subsequent difference between the undergraduate programs and traditional hospital-based program in stating:

> They are different in nature, objectives, content and educational experiences and provide the graduate practices from a theoretical base which provides reasons for selected aspects of nursing care seen to be appropriate and adequate for specific nursing situation and problems.
>
> Nursing students take a spread of required courses in the biological and behavioural sciences and the humanities designed to meet the aims of higher education. The educational process gives emphasis to critical analysis, problem solving, decision making and learning to discriminate among values.

CULTURAL CHANGE THROUGH EDUCATION

THE TRANSITION BEGINS – TWO SYSTEMS IN TANDEM

When I commenced my studies in the higher education sector a parallel system of nursing education, sometimes called a binary system (Russell 1991), was in operation in South Australia. The original pilot nursing higher education programs commenced in Australia in 1974. White (1979) explained that South Australia commenced one of these pilot programs at Sturt in 1975 with the three-year Diploma of Applied Science (Nursing) commencing with fifty-six students. The Australian pilot studies continued until 1986 when there was eventually a government decision, according to Sellers (2002, p. 158), to '... transfer responsibility for all undergraduate education programs in nursing to the tertiary sector', commencing in 1986 and to be completed by 1993.

Following the decision by the Australian government to transfer all pre-registration nursing education in Australia to the higher education sector a parallel system of nursing education for registration existed for many years, with many registered nurses graduating from hospital-based courses while others graduated from college-based courses. This parallel system remained in

existence variously for between ten to twenty years. The length of time depended on the date of the first courses being commenced in the higher education sector in each of the states during the period of transition. During the time that the students from the college were on the wards it was not unusual for the hospital-based students who I worked with to complain that the college students did not pull their weight on the ward. Each day I had to counter their complaints by trying to explain that these students had a different program of study and that they were not expected to take the same workload as hospital-based students because they were not employed by the hospital. Both the hospital-based students and many of the registered nurses who were hospital-trained often expressed their frustration with the college students. I would hear complaints such as:

- *When they are here they do not do a full shift and their clinical teacher often takes them away from the ward to talk about the patients.*
- *How can they learn to be a real registered nurse if they don't spend more time on the wards?*

> I found it difficult to respond to these students and registered nurse concerns in a way that would not offend them. I tried however to support both student groups, but it was difficult to promote one program over another in those early days of the pilot program while there were limited numbers of students in the college program and the hospital-based programs continued.

The graduates of the hospital program were aware that as students they did all their clinical experience in that hospital and were rostered on the wards as part of the workforce. I shared with them the difference between their experience and mine to show how change had been occurring over the years because by this time all their classroom time was undertaken in a study block in work hours and, unlike me, they were not required to live in the nurses' home.

In contrast, the students doing the college program were full-time students (some chose to be part time for personal reasons) with their classes being timetabled across each of the six semesters in the three years of their program. They were not treated as workforce in a health service and the college nursing academic staff arranged for the students to experience clinical practice, not just with hospitals but also in other places where nurses worked. This included domiciliary care and community health and various health agencies around the state, thereby aligning each experience with the learning required for that subject. These students were supervised by a clinical teacher when they undertook clinical placement.

Durdin (1976, p. 40), in the year prior to my employment at VGH and the year in which the first program was being established in Sturt CAE in South Australia, explained the purpose of the clinical teacher when she wrote:

> During the first year of the course, students need close supervision of clinical practice. It is believed that a teacher-student ratio of not less than one teacher to six students is desirable in all the clinical situations, and to provide supervision, all staff members need to be involved in clinical teaching.
>
> The central emphasis in the nursing curriculum is NURSING. The concurrent studies of biological and social and behavioural sciences are related to nursing – to the aspect of nursing being presented at the particular time. In the first year of the course, basic nursing skills are taught. All lecturers, being qualified nurses, can show by their participation in clinical teaching their own commitment to the art of the nursing.

When I was first working on the wards as a clinical teacher supervising the hospital-based students I came into direct contact with the college-employed clinical teachers when they were supervising their nursing students who were undertaking clinical experience at the VGH. It was at this time that I realised that the college needed to negotiate with hospitals and health services to find places for college students' clinical practice experience. Durdin (1976, p. 40) wrote that when negotiating for placement:

> It required a considerable amount of time in visits and explanation of our program and objectives, answering questions, and discussing possible problems, and we appreciate that the staff concerned in their institutions and agencies are giving up their time.

The college students who attended VGH to undertake clinical experience were allocated by the college clinical teachers to work in the hospital wards to look after the patients' needs for eight-hour shifts, the same as hospital-based students. However, they were only allocated to work on the wards for two days per week during the term time and had special objectives to cover. Unlike the hospital-based students, they were allocated to patients requiring care for specific conditions so that they could concentrate on care to integrate theory and clinical practice. The college clinical teacher often worked alongside the students while they practiced the clinical skills about which they had been learning in class. These students were unpaid labour and supernumerary to the ward staff. The clinical teacher introduced them to the patient and followed up with the student at the end of the shift to undertake a debrief of all the students, at which time they could discuss their learning for the day.

According to Pickhaver (1976) there were many misconceptions in the profession about the relationship between the two types of nursing education programs. Pickhaver, who was the Head of the Nursing Department of Sturt College, wrote to the profession to clarify for members what she believed were these misunderstandings, especially those about the relationship between the hospital and college program graduates. Pickhaver (1976, p. 35) expressed her belief that nurses understood that '... the course is designed to meet nursing needs and not taught simply for academic interest.' Pickhaver, (1976 pp. 34 -5) wrote:

> At the time of writing this article, students from the new Nursing Diploma program at Sturt College of Advanced Education, Bedford Park, South Australia, have worked in more than 30 different hospitals in that State and visited almost as many health and welfare agencies … however, we have evidence that many misconceptions about the course and its aims still exist. … The course aims to prepare students for the general register of the Nurse's Board of South Australia and also to enable them to obtain a basic Diploma (UG2 Level) as that is recognised by the Australian Council of Advanced Awards. It will therefore be equivalent to the three year basic level course and that, on completion, students will be first year registered nurses. … Our students will be looking for nursing practice as first-year registered nurses initially.

> Having said all that, the question arises, if the students are going to be only the same as students from hospital programs why do this course and be poor when the pay is fairly good for untrained personnel in the hospital program? Therein lies another fallacy.
>
> We do not claim our students will be the same, though we are asking the Nurses' Board to recognise them as being competent to be registered as general nurses. … we believe that our graduates will have skills and knowledge in the sciences basic to nursing and in areas outside the "general" syllabus. …
>
> We are able to provide a wider education because our students are not employees but full-time students who are supernumerary to the staff employed to provide nursing service. This means that during their clinical practice the first consideration is the needs of the patient for who the student is caring.

The documentation of the Sturt program, authored by Goldsworthy, Pickhaver, and Young, (1984, p. 2) identified that, '… nurses must be prepared to provide nursing skills in any situation, in or out of the institution. The program was designed with a view to enabling graduates to achieve this outcome.'

I had a very good opportunity to see the results of the graduates at first hand. In 1984 I became the in-service educator, and, in this role, I was the coordinator of the first-year Registered Nurse course. There had been college graduates involved in this course since 1979. I was in an excellent position as I worked with both groups as they made the transition to the clinical context as registered nurses. Even though I did not undertake research to prove this I noticed over the years that each group of graduates had specific strengths.

The graduates from the hospital programs demonstrated their understanding of the way in which the wards functioned and the related idiosyncrasies of the environment. They were very aware of their role in patient care and their role in the health care team. The college graduates were less aware of the idiosyncrasies of the environment however, by the time that they had completed their first rotation on the wards and with support from the registered nurses and clinical teachers, they had generally worked out the ward structure and their place in the team. Their strength seemed to be in their outgoing communication and critical thinking skills and an understanding of the scientific principles relating to diagnosis and treatment.

The graduates of each of the programs realised that even though they were all employed as first year registered nurses doing a first-year Registered Nurse course their qualification and courses had been quite different. We had many discussions about the consequences of the change and how it would affect each of the graduate cohorts.

The focus of the concerns is represented in the following scenario of the type of statements made in class by the participants during a session of the first-year Registered Nurse course. The participants would say something like: 'I did a three-year course and had to do a State final examination before I graduated and was registered as a nurse with the Nurses Board of South Australia. The college students got a diploma after doing their three-year course and they didn't have to do a final examination before they were graduated and were registered with the Nurses Board of South Australia. This doesn't seem fair because if they are successful in transferring all courses to the college it looks like I am going to have to do more education, so I can get a nursing diploma, but it won't give me any more money or status and I can't afford the time to go back to school. Anyway, I think my course prepared me better than the college course because I spent more time practicing being a registered nurse and they only spent two days a week doing clinical practice!'

> *As I listened to these types of conversations I realised that there was a great deal of work ahead of me in trying to bring these groups together. I recognised that they were our future and that the profession would only survive the change if registered nurse graduates from both programs came to value each other.*
>
> *I found working with this, my first such group, over the first year could be both a frustration and a pleasure but generally more of a pleasure.*

It was a pleasure to work with both graduate groups because each seemed to be anxious to work as an effective registered nurse. In the early days I was aware that there was some conflict in the room between the two groups. I set out to engage the registered nurses in positive activities that I hoped would enable them to understand their differences and that each had strengths and that they could learn from one another. It was pleasing to realise that by the end of the year the two groups had become one. They understood each other's strengths and weaknesses and they shared ideas with one another and assisted each other to work through issues.

The clinicians in the early years of having college graduates on their wards were very sceptical of the capacity of them to work effectively on the wards. They were inclined to make comparisons between the two graduate cohorts and often came out on the side of the hospital-based graduates. I spent a great deal of time working through the issues with the charge nurses when they were doing the Management Course that I was running in the hospital at that time. They were generally dissatisfied with these graduates because, in their opinion, they needed too much support when they first came to the wards. I had a number of them say to me that '*College graduates can't do work like the graduates from our programs'*. They were critical of the graduates' continual questioning about the care of patients and their concern that they were always meeting their legal obligations. We were hearing for the first time that registered nurses believed that they were the patient advocate and that it was their role to support the patient to achieve the best care outcome possible. The college graduates were quick to learn and were more inclined to question what they were seeing and to ask for explanations than their counterparts. The hospital-trained charge nurses on the wards would often complain that these college students and the graduates were talking lots of jargon and that they wished that they would just get on with their job.

Pickhaver (1976) had introduced the new curriculum to the profession through a nursing journal that was being published in South Australia at that time. She explained what would be involved during the three-year course, stating that the curriculum had a '*Core of Nursing Theory*'. Outlining the curriculum content, she explained that there would be significant differences in the college course to what was at that time being offered in hospital-based programs. The outline of the curriculum is presented in the table as figure 5.3.

Figure 5.3 Outline of the curriculum 1976

First Year **Study of Basic Nursing**	**Second Year** **Study of Medical and Surgical Nursing**	**Third Year** **Study of Skills of Professional Nurses**
Communication Skills Social and Behavioural Sciences Human Development Physical Sciences Biological Sciences Clinical Practice First Aid Community Health	Biological Sciences, pharmacology and microbiology Community Studies Adult Care 1 Mental Health Family Care	Community Health Adult Care 2 Adult Care 3 Theatre Recovery Accident and Emergency Intensive Care Clinical Experience Workshop Elective

Source: Pickhaver (1976, p. 42)

Pickhaver reinforced for the profession that, in addition to learning in the hospitals, these students would have opportunities to have clinical experience in community health and mental health services and that this clinical experience was aligned with corresponding patient care subjects. Pickhaver (1976, p. 42) also stated that by the third year of the course 'The theory will be concerned with issues of moral, ethical and legal aspects of care, history and professional development, teaching and administration skills.'

Having been able to access this journal through my mentor Margaret I spoke to the charge nurses about the program. I was vociferous in my conversation with the charge nurses that these graduates would be an excellent asset to the ward and to the profession, especially given the expanded curriculum content and the new clinical experiences to which the students were being exposed. I was strong in my opinion that if they were given the right guidance at the beginning of their time in the wards these graduates would be an exceptional asset to the health care system, to patients and to the profession. I further explained that it was our joint responsibility to help to guide the next generation of nurses. '*How could we ever move into the new technological age if our graduates remained in the past?*' I would often ask them.

It was not unusual for me and my colleagues to hold long conversations about what we were observing, especially regarding the disquiet that was apparent among the hospital-based graduates. I often expressed my concern that it seemed unfortunate that the graduates who were the vanguard of the new approach to nursing education were suffering as a consequence. While the directors of nursing of the major hospitals were very supportive of college education the nurses at the workface were disgruntled. Not only were the students not prepared in the way they expected but the registered nurses were starting to realise that their certificate qualification would not be adequate for the future and therefore they would need to gain a diploma that was at the same level of these new graduates. Many voiced a view that they hoped that these changes would not happen in their work life time. Like me when I did the Diploma they would have some recognition of their original training but would still need to attend class in their own time for from 2-3 years part time if they chose this new path.

Satisfactory completion of the first undergraduate programs resulted in the graduates receiving a Diploma of Nursing or similar undergraduate nursing qualification.

As stated in the preceding chapter the transfer into the higher education sector had a direct impact on the health care system, especially in relation to nurse staffing. The nursing curriculum of the higher education sector included a comprehensive approach to theory and practice and positioned those students outside the health care workforce. This educational approach required the higher education schools of nursing to negotiate with the health care system for clinical learning places for these students, who were not employees, to undertake their clinical experience. This change meant a new and previously uncharted approach to education of nurses and staffing of health services for the future.

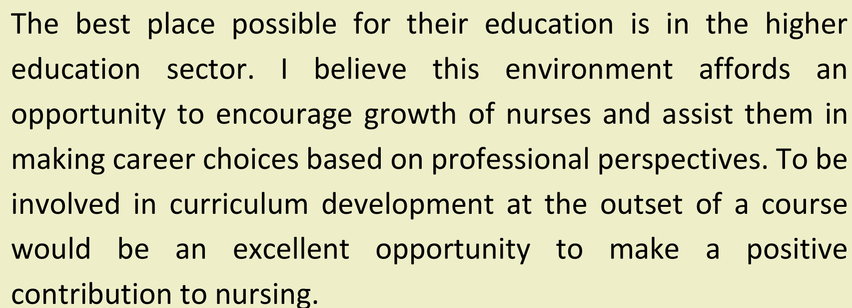
My concern about the criticism of the graduates of the college program continued. In 1990 one of my colleagues and I were so concerned about the negative attitudes of members of the nursing profession that we decided to publish an article jointly (Hills-Siegloff & Walker 1992) in a text that was to be published in Australia in 1992. This was one of the new series of nursing publications, Issues in Australian Nursing, which was edited by Genevieve Gray and Rosalie Pratt (Gray & Pratt 1992) who were instrumental in leading a new drive to have Australian nurses publish. In the article we expressed our concern that the profession was not supporting the students in the higher education program in a way designed to improve their transition to the profession (Hills-Siegloff & Walker 1992, p. 229), stating:

> The nursing profession has been remiss in not informing all clinicians of the monumental change in the preparation of nurses brought about by educating them through the higher education sector. The graduates of these early programmes have been confronted with hostile nurses requiring explanation of the changed educational method. This has been unfortunate, as the new graduates have had to spend much of their initial experience as registered nurses justifying the profession's decision to alter the training process. This should have been a time, for a new graduate, to consolidate his/her education and make an unencumbered entrance into the profession.

JOINING A NURSING FACULTY

In March 1987, when I was employed as the Principal Nurse Educator of the Royal District Nursing Society of South Australia and undertaking a Master of Nursing Administration, I received a phone call from the Head of School of Sturt CAE asking me whether I was interested in taking up a role in the school. I was, so she asked me to write a letter of application and to attend an interview. I did so and included in it my belief about the importance of teaching undergraduate students in a college-based course, see figure 5.3.

Figure 5.4: Excerpt from application to head of school March 1987



The best place possible for their education is in the higher education sector. I believe this environment affords an opportunity to encourage growth of nurses and assist them in making career choices based on professional perspectives. To be involved in curriculum development at the outset of a course would be an excellent opportunity to make a positive contribution to nursing.

Source: Lesley Siegloff archival documents

In my new role as a lecturer I was responsible for undertaking public relations with organisations who took students for field placements, teaching undergraduate community nursing and primary health care, and teaching nurse managers in the Bachelor of Management (Nursing) program being offered at this college.

At that time the pre-registration qualification for nurses was a diploma and the post-registration graduate qualification was a degree. I was completing the Master of Nursing Administration degree because of my interest in leadership and management. I was attempting to build my

knowledge of the theoretical underpinnings of administration, financial management, law and professional nursing, leadership and management.

When I took up the lecturer role to work in the college I was confronted with a new concern of the profession. Having gained our goal of the transfer, now the nurse academics were concerned about the application of theory to practice.

> *I was amazed then that we had worked so hard to have the students recognised as students who were not used as labour force and in such a short time the concern turned to ways of eliminating the theory practice gap.*

This issue was the focus of a National Nursing Conference held in the School of Nursing Studies, Sturt Campus, South Australia CAE in September 1989. I attended this conference as a member of the teaching staff. Sandra Speedy, a lecturer at the college, set the scene for the day with the content of her opening address *'The scene is set'* (Speedy 1989, p. 11):

> For some time now, there has been considerable discussion about the role of nursing theory in Australian Nursing, and some concerns that we, in Australia, ought to be focussing on developing our own "flavour" and our own approach … … So before long we found ourselves focussing on the theory-practice issue, but particularly on the nursing theory and practice issue; as opposed to theory from other disciplines.

The organisers also invited eminent international nurse leader Dr Callista Roy to give the keynote address at this event. Dr Roy was one of a number of American nurses who were developing a theoretical understanding about the role of the nurse. Roy's paper was titled '*An explication of the Philosophical Assumptions of the Roy Adaptation Model*' (Roy 1989, p. 15-34).

I had joined the college because I wanted to teach and when I was teaching in the Bachelor of Management (Nursing) course I was aware that this was the area I had come to feel was my area of special interest. In the course I taught mostly leadership and management theory. I thought about the need for me to teach more than just the theory of management of organisations. I was

teaching nurse managers and directors of nursing who were confronted with complex leadership and resource management issues daily.

> *What I understood was that, although I had completed the master's program, I still needed to bridge what I thought was my theory approach in relation to practice. I applied for, and was appointed to, the role of director of nursing of a regional hospital. I was granted leave without pay from the college to pursue this role for the next two years. I had imposed on myself this period in which I wanted to learn about the theory/practice context so that I was in a legitimate position to teach others. However, because my family circumstances changed with my husband moving overseas to work, I moved with him and while there the position I had held in the college had been terminated, so on my return to Australia I needed to find other employment. I did not return to the Sturt College for another eighteen interesting years, by which time it had become a school of Flinders University.*

The context of nursing education changed again in 1991 with the amalgamation of CAEs with universities, in accordance with the decision in 1988 of the Australian Government. The amalgamation of colleges and universities in Australia had a significant impact on the nursing education program.

Sellers (2002, p. 158), for whom I worked in the university sector many years later, considered the situation that arose for nursing because of these amalgamations in a paper that shared the outcomes of a study relating to the '*Perceptions of non-nurse academics of the discipline of nursing,*' explaining that:

> The long-standing separation of teaching and research exemplified by the existing of the binary system (of college and university) was thereby annulled, a change which led to widespread debate concerning normative values of higher education. Cowen 1996, Maslen and Slattery

> (1994, p. 250) claim that universities are now missing "a coherent image of their new roles, a comprehensive sense of common purpose".

Bennet (1996, p. 3) wrote that 'The decision to transfer nursing education from the hospital sector to the higher education sector in 1984 was, at the time, a courageous one.'

EXPANDING EDUCATION ROLE INCLUDES RESEARCH

When the transition finally occurred in 1991 I was working in Indonesia and later in a regional hospital in New South Wales. Within four years of the transfer to universities I took up a new role in a school of nursing in a university in Victoria. I realised immediately that the demands on academics had changed from when I had worked in the college. Not only did I need to teach, I was also required to be actively involved in research, publishing academic papers and with liaising with the various health care organisations which would be taking our students for clinical experience. Bennett was one nurse who wrote about the changing approach to nursing education that was having an impact on the traditional role of the nurse educator. Bennett acknowledged that, although nursing had come late to the university sector, we had an important contribution to make to the development of nursing knowledge and practice through research and scholarship. In a guest editorial (Bennett 1996, p. 4) wrote to the profession:

> Our late arrival in this area (university sector) has meant that we have had to undertake a rapid learning curve, but our efforts are being rewarded, not only in our performance against the criteria required by the university but the impact of the new knowledge of nursing and nursing practice. We need to continue to grow in this area.

Fortunately, I had learnt the importance of nurses being engaged in research when I was working as a director of nursing in a Regional Health Service in 1993. When I returned to work in the higher education sector and took up a position as a lecturer at a Victorian university I took with me a research grant and a research assistant because I was the chief investigator of a Nurse Practitioner Project. This was being run in remote Australia and the report was still to be finalised. Even though at that time there was a push to have nurses undertake research it was interesting to see that

many of my new colleagues in the University were surprised that I had been doing this research in my director of nursing role.

At that time many of my new colleagues at the university explained to me that they were very unhappy because they had thought, at the time of the transition from a hospital school of nursing, that there would be a better focus for student learning and that the teachers could concentrate on student learning needs. In the first instance this had been the case with the college programs in which they had been employed as nursing lecturers to do the teaching. In that role they could teach theory and related practice and focus on student needs, not the needs of the hospital as they had done in hospital schools of nursing. However, one of my education colleagues commented one day, when we were in the staff room, that she thought nursing was caught up in something altogether different to what had been envisaged when we were working to transfer nursing into the higher education sector. It seemed that we could achieve that which the nurses who had the idea originally had envisaged, which was to teach students the complexities of being a professional nurse in the modern health care system. She voiced concern that now that nursing education was in the university sector we not only had to teach, but also to research and to publish. *'I didn't take up nursing education for this'* she said to me, as did many of my colleagues at the time. In this nurse lecturer's view, she thought that if there are nurses who were interested then she was happy for them to research and to publish, but to let her do the teaching so that we can have well prepared nurses! Another of my colleagues complained that she thought that when one of the other educators had completed a PhD they were wasting their time. However, she realised that she was going to need to do a master's program and probably a PhD. '*How will that make our students better nurses?*' she asked me.

While I did not agree that the PhD was a waste of time I did think it was beyond my capacity. My colleagues were expressing concern that they were unclear about how they would survive in the

higher education sector in trying to teach and to do research at the same time. Among my colleagues at that time there were a number who were teaching, who read widely about teaching, but did not see themselves engaged in running research. One of my friends even explained that she thought there was probably a place for a combined pre-registration and post-registration school for practice courses for registered nurses and that other research programs should be run as a separate division of the school. This debate seemed to be the focus of many of our morning tea discussions. Many of my colleagues who had moved from the hospital program to the college program, and then into the university, were mourning the loss of the college.

Sellers and Deans (1999) alluded to these changes when they reported that, following the significant work undertaken to have nursing education transfer to the higher education sector, there was still a great deal of work for the profession to do to achieve the status of other professions in the sector. Sellers and Deans (1999, p. 53) affirmed:

> … the importance of knowledge development in advancing nursing made in the report on the review of nursing education by Reid 1994; xxiii to place nursing on the same footing as other university disciplines ….

The project '*Nursing Education in Australian Universities; National Review of Nurse Education in the Higher Education Sector-1994 and beyond'*, reported on the issues surrounding the transfer of pre-registration nurse education to the higher education sector. I returned from Indonesia in late 1993 but I had not been connected to the political activities of the profession in Australia during my absence of two years. When this report was released I thought that reading it would enable me to bring my knowledge up to date. The information that I found in it drew me into the issues that were troubling the profession of nursing at that time.

The report authored by Reid (1994, p. 33) discussed the impact of nursing education transferring into universities and the importance to the advancement of the profession, stating:

> ... whether by accident or design, entry into the universities created greater long-term potential for nursing than the old advanced education sector made possible. In the universities nursing can more fully develop its research base, which is crucial to the development of the nursing profession, and its practices and judgments.

This idea of life-long learning resonated with me as I sat in the coffee shop down the road from the book shop in 1994, where I had purchased the report. I realised, as I sat there, just how important the education and continued learning was that I had been doing and had become involved in since I was first introduced to the idea of furthering my education, as encouraged by the senior clinical teacher who took me under her wing in 1977. Education and active engagement in the profession has expanded my horizons and has been the impetus for the extraordinary journey I have travelled. It has also resulted in a very different and more engaged path than I would ever have envisaged at the time when I walked down the path of the nurse's home with my suitcase thirty years previously in 1964.

I had seen and been part of great change and had benefited from it.

CONCLUSION

This chapter relates many stories that describe my journey after graduation and while trying to find a place in nursing in which I felt safe to practice. It also told the story about how I eventually changed the direction of my career. This was achieved by taking opportunities presented to me to become an educated professional nurse interested in advancing the role of the nurse. In this chapter I also shared my journey of becoming a nursing educator in a new technological age and explored nursing education at the time of the transition into the higher education sector.

CHAPTER SIX - REFLECTIONS

INTRODUCTION

The way in which the thesis is presented through an autoethnographic lens has resulted in new insights into the evolution of nursing education in Australia from 1964 to 1994. While other stories have been written about nursing education the process of writing my story gradually revealed new understanding. What I have learnt adds a unique and complementary perspective to the current predominantly descriptive historical documents and literature concerning the way in which past and current nursing education is understood in Australia.

This thesis set out to answer two questions. The first question is '*How do my experiences of nursing education reflect what was occurring in Australian pre-registration nursing education from 1964 to 1994?*' The second part addresses '*What can be learnt from my experiences?*'

In this chapter an overview of Chapters Three, Four and Five has been written, followed by a piece that reflects on my experience of doing autoethnography. Following this section, I describe what I learnt from the study and follow this with impact and implications of the outcomes of the study. The chapter also includes a discussion identifying some strategies that could be implemented by Australian professional nursing organisations, the health care sector, the higher education sector and government departments to explore a way forward for nursing education.

Chapters Three and Five, entitled Enculturation and Transitions, contain the autoethnographic data and address the first part of the research question as well as the goal of this study which is to explore, explain and describe the participant's experience of nursing education in the period under study. In these chapters my memories are characterised as narrative and stories, and aspects of my experience of nurse education are described. To ensure veracity and verisimilitude the stories

in the autoethnographic chapters are juxtaposed against data taken from documentary sources depicting some of the activities and events experienced during this period.

Chapter Four, unlike Chapters Three and Five, is not autoethnographic in presentation. This chapter acts as a bridge between the two autoethnographic chapters. The use of the multiple documentary sources that were obtained through archival searches added other voices to my story of the nursing education journey. These documents enlightened me about aspects of the work for change of which I had previously been unaware. The information gained from these documents complements the stories of my experiences, further illuminating the connections between the shared history and experience of nurses and my own lived experience. These documents extend my understanding of the movement for change that was driven by members of the nursing profession prior to, at the time of, and immediately following my pre-registration nursing training.

As discussed in page 27 of this thesis I have striven to build a relationship between myself and the reader and to deliver a story that can be comprehended and interpreted by the reader. The presentation of this thesis has similarity to the way in which Lather and Smithies (1997) produced their book '*Troubling the Angels*'. They presented the various voices and different aspects of information in the text in a variety of positions on the page in different font styles and offering, according to Lather and Smithies (1997, p. xv), '… various levels of knowing and thinking through which a reader can make their own sense.'

In the section that follows I describe what I have learnt from this research activity under five main headings prior to which reflections on the experience of undertaking the study using autoethnography are shared.

THE AUTOETHNOGRAPHIC EXPERIENCE - REFLECTIONS

During the research journey I was finding the storylines of everyday life and making connections in a formative and iterative way as described by Goodall (2009, p. 42). These connections were often triggered by looking at a picture or reviewing the documents that I had kept in a scrapbook and a personal archive over the thirty years. The act of remembering these experiences was very emotional and I found myself at various times in states of sadness, happiness and even confusion.

I was amazed by how vivid some of the memories were and how I was drawn into that past as though I was observing rather than reminiscing about the events. During this process I recognised that I was looking at my past as an observer. Like an ethnographer, I could see the events. There were times in which I could see the events so clearly, when I was writing about my training days, that I felt as though I wanted to be able to talk again to my friends and to share again the extraordinary experiences when we were so connected through work, learning and social life.

After the initial development of the stories I left the chapters for a time with the stories written as a draft and returned to read them again with a fresh mind. Re-reading these stories and reminiscing about their meaning transported me back in time. At the time of recalling these events I explored the documents that I had found in the journals, texts and archival documents and sought to establish which of these documents had some meaningful connection with what I had written. This resulted in *crystallisation* of the material. As described by Tracy (2010, p. 844) in Chapter Two crystallization is used '… not to provide researchers with a more valid singular truth, but to open a more complex, in-depth, but thoroughly partial, understanding of the issue.' During this process I saw a connection between my experiences and certain events that occurred in the profession of which I had previously been unaware. This connection first became evident when I found the letters in the Public Records Office of Victoria that had been written by those nurse leaders who were communicating with members of government such as the Minister of Health

Victoria in an attempt to initially improve the standard of hospital-based pre-registration nursing education. Their lobbying led ultimately to the move of nursing education to the higher education sector. The nurse leaders included registered nurses, directors of nursing and nurse educators representing nursing organisations such as the Royal Victorian College of Nursing, the Florence Nightingale Committee, College of Nursing Australia, College of Nursing New South Wales and the Royal Australian Nursing Federation. The letters highlighted the concern of nursing educators that the syllabus being taught at that time was out of date by many years (Connor 1969; Whitfield 1969; Evans 1970 and RVCN 1970). Their influence on my stories was like the 'pentimento' that Denzin (2014, p. 1) described as '... something new is always coming into sight, displacing what was previously certain and seen.' What was revealed was at times surprising and assisted in driving the study forward.

The reflexive writing process gave me an opportunity to limit my overenthusiastic tendency to write too many stories. I recognised that, even though I was excited to remember the many experiences as they came to mind, it was not necessary to write down every detail that I remembered because some did not add meaningfully to the study.

I also realised that I was remembering in hindsight and that there was the potential for my memories to be just imagination or at least somewhat distorted. I was aware of the concerns that had been expressed about using personal memory to develop narrative in research (Chang 2008; Denzin 2014). The narrative developed from my memories into stories made a connection with the experiences depicted in the literature and documents that have been used to limit the potential for self-indulgence or solipsism.

When doing this research as an autoethnographer there were times when I felt as though I was experiencing a personality change as I moved between being the subject and being the researcher.

My various personalities included being thinker by drawing on memory and spending many hours thinking about my experiences, observer, narrator and writer of the nursing stories of my past, and as investigator. In the role of the investigator searching through the various archives I found many documents that shed new light on events of which I had not previously been aware. Some documents were well catalogued, others were a haphazard assortment of documents that had been placed in no special order into boxes, and some were found in libraries where old journals are now stored.

During the experience of searching the archives I felt like an explorer and found it difficult to draw myself away from the many boxes that held so many wonderful memories of the history of nursing education in Australia. I recall now the wonder and excitement of finding the letter written to the Victorian Minister for Health by Whitfield in 1969, especially when I realised that the author had been my Principal Tutor at the time of my training. Sitting in the Public Records Office of Victoria in Melbourne on that day I was initially nonplussed. This was followed by excitement because I had come across a document that I had not previously known existed. It occurred to me at the time, because the letter had been filed among the documents held in the Minister of Health's files at least thirty years previously, that I may have been the first person to lay eyes on these documents since that time.

As I worked through this study as both the researcher and the subject my experience was like that which I identified in Chapter Two as being characteristic of autoethnography. I felt like I had truly assumed the role of autoethnographer as described by Ellis (2009, p.9), who wrote:

> As an autoethnographer, I am both the author and the focus of the story, the one who tells and the one who experiences, the observer and the observed … I am the person at the intersection of the personal and the cultural, thinking and observing as an autoethnographer.

Also, in this thesis I have been able to write in the way that Wall (2006, p.1) attributes to the author of autoethnography '... a highly personalized style, drawing on his or her experiences to

extend understanding about a societal phenomenon.' Cultural connection was also made through '… connecting the personal to the cultural' (Frank cited in Peterson 2014, p.3).

In the following part of the thesis the five major outcomes that have emerged from analysis of Appendix 13: Timeline of change in nursing education 1964-1994 – Comparison, are explored.

WHAT I LEARNT

To connect with what I have learnt from this study, I read and re-read the chapters many times and reflected on salient developments and results of actions or events. The outcome of this process has been the development of a very complex picture of interactions among culture, professionalisation, politics and social development. Analysis of the contents of Chapters Three, Four and Five allowed me to see more clearly those interactions that I discovered had occurred throughout the period under study.

In the next part of this chapter the insights that I gained from this research are discussed. They have become the outcomes of this thesis. They are:

- An echo of the Florence Nightingale Era
- Unsupervised, unskilled cheap labour
- Aspirational visions not shared
- Two systems - professional equals or confusion?
- The separation of nurse education from nursing practice context

The impact of the separation of responsibility from the health care sector for nursing education still resonates today and will be addressed following discussion of the five outcomes listed above.

AN ECHO OF THE FLORENCE NIGHTINGALE ERA

While developing the stories arising from reminiscences from my training days, which are included in the thesis, I learnt that my main duty was to be an attendant to patients and this was to include all domestic duties and associated tasks in the wards.

In Chapter Three I am introduced as a young compliant seventeen-year-old girl who was brought up in country Victoria and who undertook nurse training, as was expected by my family and to follow in my mother's footsteps. I settled well into this life with all the rules and expectations placed on me by Matron and the Principal Tutor. I was used to rules because while growing up I had similar expectations placed on me at home by my parents.

As I read and re-read what I had written it became apparent that the nursing role that I learnt was an echo of the nursing way of working described by Florence Nightingale, approximately 105 years prior to my training days, in her *Notes on Nursing* (Nightingale 1969).

Over the ensuing years nurses have valued this document as one of the first foundational texts from which nurses were taught to understand nursing care. It was written '… to assist millions of women who had charge of families to think how to nurse' (Dolan in Nightingale 1969, p. v) and over the years has become a '*sacred*' text within the nursing profession. Australia's first nursing school was established in Sydney Hospital by Lucy Osburn, a student of Florence Nightingale. According to Godden (2006) Lucy Osburn's nursing programs of the 1860s embedded an emphasis on nurses' domestic housekeeping role, including hygiene work as well as basic patient care, and attention to rules of behaviour. The stories that I have written describing where and how I was educated in the 1960s had extraordinary similarity, a century on, to Lucy Osburn's first program. This emphasis on teaching students predominantly about domesticity was regimented, not evidence based, and arguably lacking a scientific basis consistent with scientific rationale and principles current in the 1960s. This was recognised by senior nurse educators of the time who believed that nursing education was outdated by many years (Whitfield 1969). This realisation underpins the idea that nursing was potentially very outdated for the times and ripe for change. In the ensuing years, while the basic care aspect of nurses' work has always remained important, medical and scientific advances have impacted significantly on the outdated Lucy Osburn

approach, extending the scope of practice of nurses and dramatically influencing the nursing curriculum.

Chapter Five records how the changing nursing curriculum was becoming evident in hospital-based programs. Included in the curriculum changes was an increased focus on physical science subjects and the behavioural sciences (Finlayson 1976, Pickhaver 1976). Students were being introduced to learning about basic anatomy and the common pathologies that they may encounter and about communication techniques that were designed to improve patient outcomes. This coincided with the introduction of the college education curriculum in which physiological and behavioural sciences, pharmacology and microbiology were taught in a gradually more in-depth approach (Pickhaver 1976). According to Pickhaver (1976, p. 36), writing about the development of the first CAE curriculum in South Australia, by the third year of the new college program students would be exposed to clinical venues offering community health and mental health experience and subjects that were concerned with '... issues of moral, ethical and legal aspects of care, history and professional development, teaching and administration skills.'

When I was first introduced, through my learning experience in the Diploma of Teaching (N.Ed,) to both verbal and written communication strategies designed to support patient care I realised that I could improve my relationship with the patient and with the students who I was teaching at the time. The taking of nursing history was introduced with the new approaches to nursing practice that resulted from improved patient communication. Nurses were learning more about patients as individuals rather than just their diagnosis because talking could lead to a better understanding of the patients' needs and the patients would learn more about the type of care that they would receive. Such interaction helped to put patients more at ease and led to improved patient care and outcomes. When students engaged in compiling a nursing history the information that they

gained about the patient assisted in informing the patient care plan and enhancing their knowledge and effectiveness.

As well as the changing approach to communication there was also a changing understanding of patient care emerging from improving scientific knowledge. This is evident in Chapter Five where nurses were being introduced to new practices such as changing pressure area care based on evidence from research, and in Chapter Three with the introduction of new approaches to respiratory care using new medical technology. Such new innovations had a significant impact on what hospital-based nurses needed to learn and ultimately highlighted the need to move away from student nurses being merely compliant and task orientated as they had been prior to the 1970s. These innovations demonstrated a quite rapid and remarkable move into a new form of nursing requiring new knowledge, skills and therefore education. A consequence of this was that nurses had less time for performing other more mundane domestic and menial tasks.

UNSUPERVISED, UNSKILLED CHEAP LABOUR

The strength of opinion that students were the backbone of the hospital delivering all the nursing care prior to the transfer of pre-registration nursing education into the higher education sector is very evident in both Chapters Three and Five. The experiences shared in Chapter Three of this thesis reveal that the nursing role expected by health services management prior to 1971 was one that included students doing most of the routine patient care. This included undertaking standard patient care tasks, ward and patient cleaning and following medical orders. There existed in the health care services an expectation of student involvement with this work that had been in existence since Lucy Osburn introduced nurse education to Australia.

The student nurse’s engagement in domestic duties remained in operation for over 100 years. As a young woman I was employed in the position of a student nurse, however my time as a ‘*student*’

rather than a '*nurse'* on the ward was limited. I spent approximately 800 hours in the classroom over the three-year duration of my training. The rest of my time as a student was spent on the wards doing either domestic duties or patient care. During the years of training my peers and I were effectively unsupervised, unskilled and cheap labour. The engagement of student nurses as primarily labour force in the 1970s was also acknowledged by Nicholson (1992). On reviewing the story of my training days in Chapter Three I also became aware that there were very few registered nurses employed in the organisation. This hospital relied on students for most of the workforce and at the time of my training I did not see this as an issue. I came to accept that the student nurses were the workers and the registered nurses were generally not engaged in direct patient care but were responsible for overseeing ward or hospital staff.

When exploring Chapter Five I learnt that as my training progressed there was very little change made to the curriculum to consider the complexity of care that was emerging because of new medical technology and pharmacology. Although I realised then that I was not always knowledgeable about how to deal with this new complexity I did know that I was expected to cope without comment and made every effort to do so. Ironically the Principal of the nursing school where I trained had been among the senior nurse educators who had identified that the nursing curriculum needed to change in response to the changing medical and scientific knowledge that had become evident in the 1960s (Whitfield, 1969). To enable changes in the curriculum that were required to meet these new care demands and new role in the future, the Victorian nurse educators were engaged in lobbying to have future classroom hours in hospital-based courses increased (RVCN 1970).

The lack of education about how to deal with the new approaches to practice had an impact on me after I graduated as a registered nurse. At times I felt inadequate and not able to competently undertake what was expected of me as a registered nurse working in the wards.

As I reflected on what I had written in Chapters Three and Five I realised that I had sought a safe place to work after graduation, one where I would not be called on to expose what I thought were my inadequacies. I took up my first role in the operating theatre because in my opinion what I had learnt during my training had prepared me better for this role than a role that would leave me responsible for a ward.

By the mid-1970s there was a gradual change to the way in which students were perceived as members of the hospital labour force. Ward cleaning was gradually disappearing from the hospital-based student nurse's role, their work focusing more on patient care by this time. Because of the lobbying by the nurse educators, and the eventual support for the new curriculum by the government, by 1976 classroom hours were increasing and nursing students were being recognised primarily as students and given time to learn in both the classroom and on the wards. Victoria had implemented its 1600 teaching hours and new syllabus. In South Australia domestic staff were being employed to undertake most of the ward cleaning and student nurse learning had increased to 1000 hours of classroom time. At this time New South Wales released a new syllabus of 1000 hours of theory. With the introduction of new classroom hours teaching now took place during working hours rather than after the students had completed ward shifts. Unlike my experience of working unsupervised on the wards while learning from other students, clinical teachers supporting hospital-based students became evident in the early 1970s. Their role was to supervise effective student learning.

The eventual agreement to increase classroom hours in Victoria meant that the students would have their classroom time approximately doubled (RVCN 1970). Prior to this increase in classroom hours the prediction that this would occur caused concern for many of the employers. The concern revolved around the potential decline in the number of students who would be available to work on the wards if students spent more time in the classroom. Employer groups such as The

Country Hospitals' Association and The Metropolitan Hospitals' Association (1971) expressed these concerns to the Victorian Minister of Health. These organisations predicted that there would be a major financial impact on the hospitals because, due to the changes in the curriculum, they would need to employ more student nurses to replace the students who were in the classroom, more nurse educators and to improve their school of nursing facilities. In their communication with this Minister they also expressed their dissatisfaction at having to arrange placement for, and to fund, students' placements in other health facilities so that the students could extend their experience further than that which was available in the hospital.

The impact on staffing was also drawn to the attention of the Minister of Health by the President of The Royal Melbourne Hospital. In his letter Frew (1976) pointed out that the increase in classroom hours was having such an impact on the hospital that there were inadequate numbers of nurses available to cover the ward requirements. The hospitals were confronted with the need to change their staffing arrangements. However, using more registered nurses had a significant impact on hospital budgets and coincidentally there appeared to be a shortage of registered nurses at that time (Frew 1976).

Reflecting on this situation it appears that hospitals believed that they were only responsible for nursing education in their own hospitals, essentially to provide for current and future nursing staff requirements in their individual hospitals. The predicted changes to classroom hours, as well as the expectation that they were to find placements in the community for the students, had not been on their agenda. These hospitals' financial viability was contingent on the availability of students to perform most of the nursing and associated domestic work. Confronted with such significant change, over which they had no control, tension between employers and the nurse educator lobby increased.

Nurse educators responsible for lobbying for the changes were focused on their goals for change. There is no evidence to suggest that they had considered the potential impact of the change on hospital staffing however they remained convinced that the outcomes would improve patient care. It is unclear whether, when setting the goals for change in classroom hours, there was an opportunity for the nurse educators lobbying for change to work with the health care employers to understand the potential impact on workforce while achieving their goals.

In effect, it appears that the situation created adversarial attitudes as the health care sector and the nursing profession pursued their individual and important self-interests to the detriment of maintaining strong bonds between them for a continued common interest in nursing training and nurse workforce. This may have been one of the reasons for which, over time, the health care sector progressively relinquished responsibility for the education of nurses. The responsibility passing to the profession and external educational institutions resulted in some challenges in establishing real world clinical experience in hospital systems for nursing students during their training.

ASPIRATIONAL VISIONS NOT SHARED

An exploration of the thesis data chapters revealed that two approaches to lobbying governments were occurring simultaneously. First, Victorian nurse educators were identified as seeking agreement from the Victorian Government for an increase in the number of classroom hours and removal of students from being primarily labour to being primarily students learning in the classroom and the wards (RVCN 1970). Simultaneously there were nurse leaders from various associations and organisations from around Australia who were seeking agreement from the Australian Government for a transition of nursing education to the higher education sector (Donaghue 1975). Essentially, there were two initiatives designed to change the way in which pre-registration nurses were educated occurring simultaneously. I did not fully understand that both

initiatives were simultaneous until I had written about each of them during the development of the data chapters. Both groups were concerned that the health care sector was changing with the introduction of new scientific knowledge that coincided with increases in patient care medical technology and therefore the need for nurses to learn and to competently practice good patient care by using the latest technologies.

The two initiatives were being driven by two different nursing groups who were both calling on government bodies and seeking a change in the way in which nurses were educated. In effect, despite their common interest in modernising the nursing curriculum, these two nursing groups could envisage quite different possible futures the way nurses were educated to understand nursing care. Notwithstanding the manner of education both groups envisaged the standard of nursing care able to be provided by future graduates to be similar in that they both recognised that nurses needed to be able to demonstrate a high degree of skill, knowledge, practice and competence. This included a capacity to communicate with allied health professionals across the health care team, and by using new technologies being able to assess the condition of the patient and to respond to and report changes in the patient condition. In order to perform effectively in such a new environment, it was felt that nursing graduates, in addition to having more highly developed skill sets and knowledge base, would need to exhibit a high standard of professionalism and a level of independence appropriate to the situation of being one among equals in a group of health care professionals.

On reflection I wonder whether the two simultaneous initiatives left some stake holders confused and resulted in some questioning in relation to what it was that the profession really wanted.

TWO SYSTEMS – PROFESSIONAL EQUALS OR CONFUSION?

Essentially, there were stark differences in the educational approaches and expectations of the trainee from the time when I was doing my training, spending time primarily as labour at the hospital where I trained, to the time of the transfer of responsibility of pre-registration nursing education from the hospitals to the college and ultimately to the higher education sector.

A significant outcome of the transfer to the college system was that student nurses stopped being cheap labour for hospitals and became legitimate learners in scholarly environments where questioning and initiative was valued over blind obedience. This outcome resulted in changing the expectations of the nurses' place in the health care sector.

The first college programs were commenced in South Australia, Victoria and Western Australia as pilot programs (Durdin 1991). In Chapter Five it became evident that during the transfer of nursing education some hospital-based nursing programs continued concurrently with the college-based programs. The result was parallel nursing pre-registration courses operating between 1974 and 1993, which in some states extended for periods from ten to twenty years. These two educational cohorts worked in parallel rather than as integrated teams of students, even when they were working on the same wards. Each of the cohorts had different learning objectives, professional goals and qualifications. The resulting binary system of nursing education continued for a period that was essentially the span of an average career.

Ultimately the graduates from each of the programs were registered with the Nurses Board of the state in which they completed their studies. There was no distinction made, either by the registration authority or the employing bodies, between the two programs even though the hospital-based students graduated with a certificate and the college-based students with a diploma in the first instance. Later this became a degree program. Graduates from each of the

programs were also eligible to apply for the same first-year registered nurse roles. When employed in these roles they were paid at the same rate of pay whether they graduated with a certificate, diploma or degree.

Through the years in which the parallel pre-registration nursing programs were in operation the difference in the way in which graduates from each program carried out their duties was often compared and criticised, especially when they worked side by side. New college graduates were often found wanting by the incumbent hospital registered nurses, hospital graduates and by those who ran the wards. The college graduates in turn were also inclined to see inadequacies in the knowledge of hospital educated nurses.

These perceived deficits often went unchallenged and had the potential to contribute to insecurities in both cohorts. The resulting tensions ultimately stimulated uneasy relations between the groups. The parallel pre-registration nursing programs resulted in a new culture in which the two cohorts often lacked trust in one another.

An increasing focus on nursing philosophy and the professional role of nurses evident in the college curriculum engendered more personal responsibility and an advocacy role for the patient that had not previously been expected of nurses. The resulting new ways of thinking caused college graduates to be more questioning, resulting in hospital trained registered nurses complaining that these nurses had moved away from what they perceived as the traditional role of the nurse.

As well as the conflicting ideas about the two approaches to education the long period during which they co-existed could also have contributed to confusion about the learning that was required to become a registered nurse. This perception would be reasonable because both graduates were employed at the same level in the health care sector for many years during which

the certificate did not have precedence over the diploma or the degree or vice versa. During the ten to twenty years of the parallel training system both hospital and college trained nurses co-existed and were ostensibly recognised as being equally able to perform ward duties. However, given that there were two systems working effectively at the same time, it remains unclear whether consideration was given to options for change other than the eventual transfer of all responsibility for future nurse education away from the health care sector. Some registered nurses put forward an alternative position for change. Their position was that the hospital-based system could be maintained if the education budget was quarantined from the hospital administration budget and that nursing students were supernumerary when working on the wards (Donaghue 1975). There was obviously some value in both systems that may have provided the opportunity for a different approach for the future including melding the best of both systems. The long-term acceptance of nursing qualifications from both programs during the transition has led to continuing divisions of opinion about whether hospital training or higher education training produces better nurses, and ultimately why it was necessary to transition to higher education exclusively.

THE SEPARATION OF NURSE EDUCATION FROM NURSING PRACTICE CONTEXT

Nursing leaders were visionary about the transformation of nursing practice with a desired outcome of improved quality of patient care, as they had proposed in the Goals in Nursing Education developed in 1975 (Donoghue, 1975). However, the impacts of the change have left their mark on the profession and the attitudes of members of the public about nursing education, some of which were the motivation for undertaking this study.

Reflecting on data detailed in Chapter Four it appears that the nursing organisations involved in the Goals in Nursing Education Committee Task Force did not keep the public and nursing

profession well informed or up to date about what they were doing to bring it about. The reason for this may be the widely accepted view, in existence since the inception of the first student nurse courses more than 100 years previously that student nurses were the foundation of the hospital workforce. During this time nursing students were seen by patients and the community as doing the care and the cleaning on the wards and learning on the job. Unfortunately, as shown in Chapters Three and Five, this method of nurse teaching on the job did not always produce confident registered nurses. This is borne out by my own experience of feeling inadequately prepared on graduation to effectively perform all the duties expected of me as a registered nurse.

The lobbying for change by the profession was not understood by many in the community and by some of the profession. There was little information about the desired changes offered in publications for general circulation to inform the public. What the public did see was nurses causing disruption when they marched in the streets of Adelaide to show displeasure at various government decisions. This included the march held to influence the South Australian Government to keep Sturt College open, and the march designed to bring to the attention of the government the professions belief that the recommendations of the Sax Report were inadequate, when a burnt document was presented to the Australian Minister for Health. These events resulted in letters to the editor of newspapers, some of which are presented in Chapter Five. The letters to the editor by the public were generally critical of what they saw as the removal of nursing students from the most appropriate place to learn which, as they saw it, was the hospital.

It would appear that the reasons put forward for change were not evident to the public. There were some members of the profession and public opposed to the change from the outset. This is evident in Chapter Five of this thesis. It is not clear how the message from the Goals in Nursing Education Committee Task Force may have been made stronger and more acceptable. Perhaps this movement for change was handicapped because it was not a shared goal of all those in the

profession, with the consequence that it did not present a wholly united professional view to the public.

If the public had been better informed about the view of the nurse educators that nurse education was out of date by many years and that by continuing to use students as the workforce the best qualified nurses would not be doing patient care, then more widespread support for a change in nursing education may have resulted. In any event, the entrenching of self-interest attitudes may have hampered the consideration of alternative transition processes by the health care sector, the nursing profession and government.

When the Australian Government gave in-principle agreement for the transition of all responsibility of nursing education to the higher education sector the Chairman of the Task Force for the Goals in Nursing Education declared that their objectives had been met (Cochrane 1984). This organisation held a meeting to disband in December 1984, leaving responsibility to the individual state nursing professional organisations to follow through with the transition. On reflection it would appear that the disbandment of the Task Force and the handing of the next stage of the process to individual state nursing organisations had the potential to fragment the process, leaving them to negotiate the establishment of their own state's nursing education arrangements without Australia-wide co-ordination.

It is felt that, although it had achieved its goal, the Task Force could have re-evaluated its position and changed the focus of its work to accept responsibility to see the whole process through to the end, thereby ensuring consistency of approaches across Australia. Perhaps such an approach could have maintained a better connection between the nursing profession and the health care sector. It is important to recognise that the involvement of different levels of government at the time complicated the issue. State Governments were responsible for the operation of colleges but were

dependent on their funding from the Federal Government, which meant that the nursing profession and the health care sector had to manoeuvre a course of action that was acceptable to both levels of government simultaneously.

A new situation also arose for the profession in 1987, prior to the completion of the transition of responsibility of nursing education to colleges around Australia in 1992. An announcement was made by the Australian Government to abolish the advanced education sector with the amalgamation of universities and CAEs. This event changed the original goal that nurses would be educated in a college course, therefore a new direction was taken on the education journey.

Interestingly, at the time of these significant changes there were still hospitals accepting students to commence a hospital-based course for registration. The last intake for hospital-based education in New South Wales was 1987 graduating in 1990, and for Queensland the last intake was 1990 graduating in 1993. This situation must have been sending very mixed messages to both the potential registered nurses and to the community. Why would it still be valid to train in a hospital as well as being acceptable to gain the same qualification in a university? The Task Force for the Goals in Nursing Education, had it not disbanded, would have been in an excellent position to argue the case appropriately for the profession given their history reaching back to 1973.

The transition of nursing education now entered yet another new era with the amalgamation of colleges with universities, an era of students engaging in research as well as learning about clinical practice. Chapter Five (pages 208 to 212) of the thesis reveals that from the early 1970s and into the 1990s the nurse's role was being influenced by evidence of new care initiatives because of nursing and health care research. The introduction of research to nursing was identified in Chapter Four where Reid (1994, p. 33) is quoted:

> ... whether by accident or design, entry into the universities created greater long-term potential for nursing than the old advanced education sector made possible. In the universities

> nursing can more fully develop its research base, which is crucial to the development of the nursing profession, and its practices and judgments.

This meant that nursing students' learning was expanding to include the use of and doing of research. They were becoming actively engaged in creating the evidence that would be used to improve practice. This was a significant step forward from using evidence in the way in which I had been aware in the 1970s.

However, as was evident in Chapters One and Five of the thesis, the public and registered nurses were more concerned about students learning to do clinical practice. Research skills were not on the agenda in those early days. This situation caused more distance between the registered nurse who had graduated from each of the programs.

The profession believed that all patient care should be the responsibility of registered nurses but did not believe that this was being achieved through hospital-based training in its current format. There was a determined push for a change in nursing education to college education to the exclusion of hospital-based training however there was no evidence put forward that the advanced education sector could do it better than the health care sector, albeit with a modernised curriculum. The fact that the parallel system produced hospital-trained nurses who were accepted for registration for some twenty years suggests that there may have been alternatives to the complete transfer of the program of education to the higher education sector. The outcome eventuated in a separation occurring between nursing education and the health care sector, which was effectively a separation of education from the practice context. Had a more nuanced approach to nursing education been agreed by an amalgamation of the best of both curriculums this may have eliminated the loss of connection of nursing education to basic practice and prevented some of the subsequent criticisms.

THE IMPLICATIONS OF THE SEPARATION

The result of the separation has been a more siloed understanding by both the health care and the university sectors, of recent times, about responsibility for the development of nurses and the profession. This separation has resulted in more commercial and competitive arrangements driving the availability of the clinical practice placements in the health care sector on which the nursing students and the education system rely. This separation has also resulted in an official distancing of the nurse educators from the health care sector and ultimately it has been a challenge to maintain relevancy in curriculum. Equally over the years the nurse academics who entered the higher education sector with expert clinical skills and knowledge have been experiencing a decline in their contemporary knowledge brought about by their lack of connection with the health care sector. One way of attempting to fill this knowledge gap has been that many schools of nursing employ registered nurses with the required competencies to do some of the required teaching in the clinical laboratories of the schools. In many cases, while these nurses are clinically up to date, many do not now have the required educational qualifications that would enable them to obtain full rather than contractual employment in the schools. Without these knowledgeable clinicians and a strong connection with the health care sector there exists a potential for a theory practice gap to occur.

The potential for a gap to occur between the theory and clinical practice was identified by nurse educators who attended the nursing conference at Sturt CAE in 1989 as identified in Chapter Five of the thesis (p. 236.) In an attempt to resolve some of the issues relating to the distancing of the nursing school from the health care sector some original approaches to student placement were devised, including the Dedicated Education Units (DEU), which were in place for several years in South Australia (Edgecombe et al. 1999). However, in the years since the transition was completed the number of schools of nursing has increased significantly and as the years have gone on not all

health care services continue having an interest in the DEU. The placement of students in the health care system has become very competitive. Placement opportunities for each of the educational facilities can change annually and depends on the health care and related organisations' interest in taking nursing students. Some are now demanding payment for taking students for placement, which has resulted in further distancing of the education and health care sectors. This situation may have occurred because the two systems of education and practice are not aligned, oft times resulting in the content of the curriculum drifting and being in some ways divorced from the practical and real skill needs evident in the health care system. Although the schools of nursing are required to have members of the health care sector on their curriculum development committees such input does not always guarantee that the result will be viewed by all parties as an appropriate and all-encompassing curriculum necessary to prepare registered nurses for their ever-changing role in the health care sector.

Questions that arise from the preceding discussion on the implications of the separation are presented below. The motivation for these questions has its genesis in the idea that the separation may have been the result, at least in part, of the way that the Goals in Nursing Education Committee Task Force was formally brought to a close. The closure occurred after the announcement by the Commonwealth Government of the total transfer of basic nursing education to the higher education sector by 1993 (Cochrane 1984). The Goals in Nursing Education Committee Task Force had a structure in place and years of strategic involvement that could have been helpful in maintaining a national approach to the initiatives. Therefore, even though the future planning was to be undertaken at state level, one speculates whether the process of transfer could have had a more coordinated and strategic approach had the Task Force remained engaged and a national discourse continued at least until the transfer had been completed?

The questions focus on the possible impact of the transfer on nursing education today. Although it may not be possible even in hindsight to answer these questions they are offered as a way of seeking understanding of possible alternatives to the full transfer of nursing education to the higher education sector.

- Was the only option for improving nursing education the transfer of all responsibility for nursing education away from the health care sector?
- Could the courses have been linked to the health care sector, which may have developed stronger bonds and kept the profession more closely aligned to the health care sector?
- Could the tensions created between the hospital-trained and college-trained nurses because of the parallel system of nursing education have been avoided?

IMPLICATIONS OF THE STUDY

The current situation of separation of responsibility clearly has implications for the way that teaching and learning of nursing students are supported in the health care sector. This section includes a discussion suggesting the types of strategies that could be implemented through the profession, health care sector, higher education sector and government departments to explore a way forward for nursing education which has the potential to eliminate the separation identified in this thesis. These strategies are covered under the headings Education research, Professional nursing organisations, Policy, and Practice context. Some of the strategies would require various groups with an allegiance to the profession to work together to bring about change.

EDUCATION RESEARCH

It has been argued that significant separations of the education sector, the health care sector and professional nursing organisations have occurred resulting from the transfer of all responsibility

for nursing education to the higher education sector. In view of this I propose future research designed to bring the goals for nursing education of the various sectors closer together by:

- Identifying the current knowledge and skill requirements of the health care sector of first-year registered nurses.
- Comparing the content and outcomes of the nursing curriculum against the requirements of the first-year registered nurse role.
- Undertaking pilot studies of health care system embedded higher education courses and exploring how such collaborative approaches could benefit both parties
- Exploring international systems to establish if there are examples where the nursing schools in the higher education sector and the health care sector maintain their strong ties and a unified commitment to pre-registration nursing education.

PROFESSIONAL NURSING ORGANISATIONS

Professional nursing organisations in Australia could take a strategic leadership role by joining forces to establish a Task Force to develop and drive a strategic plan for the future of nursing education. In much the same way that the nursing profession developed goals in nursing education for the transfer, the various arms of the nursing profession, including such organisations as the Australian Nursing and Midwifery Federation, the Australian College of Nursing, the Deans of Nursing Australia and New Zealand and the chief nurses, both state and federal, could take a leadership role in establishing a contemporary approach to goals in nursing education. These bodies could collaborate with state and federal government and other appropriate bodies to investigate strategies to reduce the issues that have resulted from the separation.

POLICY

An option to be considered may include the redesigning of traditional teaching hospitals to include nursing students. This initiative would require the expansion of the scope of recognised teaching hospitals to include nursing students and potentially other health care professional students into

the system in a similar way to that in which medical students are connected to the health care sector.

Current government funding arrangements for student nursing clinical placement may need to be changed. This could mean direct funding of the health care sector rather than the higher education sector where it relates to nursing education such as pre-registration nursing students' clinical placement, teaching and learning. Such arrangements would require the quarantining of funding in budgets and reporting of use and outcomes by the health care sector.

PRACTICE CONTEXT

It may be necessary to include in the role descriptions, of all levels of registered nurses working in the health care sector in both management and clinical roles, key performance indicators that focus on an obligation to engage in supporting placements and teaching nursing students. This may also include a review of existing enterprise agreements.

CONCLUSION

This chapter summarises the outcomes of the study. Initially reflections of the experience of undertaking this study using autoethnography are made and the five major outcomes of the study are identified and discussed. These outcomes are: An echo of the Florence Nightingale Era; Unsupervised, unskilled cheap labour; Aspirational visions not shared; Two systems - professional equals or confusion; The separation of nurse education from nursing practice context. As identified, the outcomes of the study have revealed that the result of the separation has been a siloed view of the health care sector and of the higher education sector about the system responsible for the clinical placement and clinical experience of students of nursing. The implications of the separation are discussed.

This chapter also includes a discussion identifying some strategies that could be implemented through the Australian nursing professional organisations, the health care sector, the higher education sector and government departments to explore a way forward for nursing education that may have the potential to eliminate the separation.

The use of autoethnography has proven to be effective in illuminating my experiences of the changes in nursing education during the period 1964 to 1994. It has also revealed several important new insights into the processes of change that influenced the development of nursing education, missed opportunities for collaboration and possible solutions to the separation of nursing education from health care delivery that we experience in the current system. It is hoped that the outcomes will contribute positively to the continuing debate about nursing education and help others to support the profession in its pursuit of quality nursing education into the future.

APPENDICES

APPENDIX 1: BREAKING OPEN THE DOCUMENTS-JULY 2010

I entered the hospital by the front door having walked from the railway station across the road from the hospital; the station where the train came to let me off whenever I went to the city during my training days. I had, as I walked down the road from the station, caught a glimpse of the sea at the end of the street where the hospital stood. What a strange feeling to be returning to this important building where my career had commenced. I was full of emotion and as I walked into the building I realised that the entrance to the hospital was mostly unchanged from the entrance that was added to the hospital in about 1965 while I was undergoing my nurse training. I looked to the right almost expecting the Matron to emerge through the door, dressed in full uniform with long sleeves, full white veil and red cape; but of course, she was not there. She had died a year earlier in her 90s. (She had been a nurse in the 2nd World War.) Instead, I went to the admissions window and asked for the Director of Nursing, but he was not available. They told me that they had been advised that I would be arriving and that I could have access to the archives rooms where the documents I was looking for were located. It was strange, here was a familiar place to me even after over forty-five years but nobody knew me. I was asked to sign in and to clip on a visitor's badge and was then taken by the security man into the hospital.

As I walked along I tried to remember my old land marks. The building was much the same but there were also many changes. On my left where I thought there should be a door to the Female Wards was a closed door with a sign for the short stay unit, an innovation of the late 20th Century. On the walls photographs of the hospital as it was in the 1920s were displayed that had not been there 'in my day'. Amazingly the ward in the photographs looked the same as it had during my training days, the only difference was that there were no curtains around the beds and the nurses' uniforms were longer in the 1920s than mine had been.

I was directed to a room at the top of the two-story hospital building. There I found several archive boxes lying on the floor collecting dust. There was no order to the room - it was such a sorry sight. I wondered what I would do next - how could I work out which box I needed? Then I realised that there was a year date of resignation on the outside of each of the boxes. I looked at the first one dated 1967 but had no luck, then searched around for another, I found it and there in a manila folder marked with my name were the documents relating to my application to become a nurse, dating back to 1963. They included dental records, entrance examination, Matrons' letters requesting references from the parish priest and other important people including my school principal. There were also documents relating to my learning experiences when I was a trainee nurse. They included clinical practice records of the periods of time that I spent in each of the wards and departments of the hospital during my training and reports written by the Matron (It was interesting to note that the Principal Tutor Sister did not write any of the reports on my records). As I was going through the file I realised that there were some records missing and wondered where I might find them. Then I remembered I had worked there as a registered nurse after my marriage. I went in search of another file and eventually found a box that contained a file with the name *Sister Lesley Siegloff* written on the outside.

There I found some more records. I felt some sadness that these records were not well looked after. They were the past and it seemed that the care of past documents was not a priority in the hospital.

It was a very strange thing to see that what I had always thought of as so important to my first experiences as a nurse had become so unimportant to the organisation that the records were effectively discarded in this manner. I was glad that I had come to resurrect them. I knew that although the documents seemed unimportant to the organisation I would not be able to remove them. The Director of Nursing had returned to the hospital by the time that I emerged from the upstairs room where the boxes had been stored, so I asked permission to make photocopies of my documents. He gave me this permission and he also gave me access to a book that had been written by Strahan in 1991 about the hospital. I asked if I could go somewhere and read the book and was directed to the coffee shop.

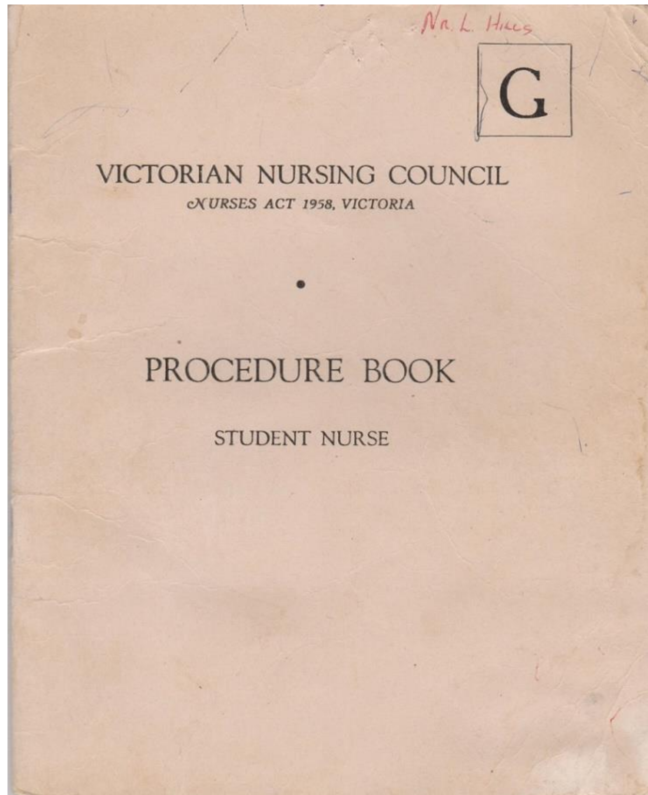
I walked down the side of the building - old red brick with curved window ledges. On my left was an old building that evoked a memory. I looked to my right and saw, not what I had in my mind's eye, but a new building that took over the space I had expected. I had a flashback of myself as a young nurse coming out of the door ahead of me at night. It was a half flywire door which was at the back of the female public ward. It squeaked loudly and banged shut if you didn't hold it. I remembered wheeling a mortuary trolley. I was wheeling the body of an old lady who had recently died to the mortuary. The body was covered in a sheet that was blowing in the breeze. I was alone as I wheeled the trolley across the hospital yard to the small brick mortuary. I waited outside the door to be let in by the night supervisor who had the key and let me in. We wrote the name of the lady in the mortuary book and left her there on the trolley to be picked up in the morning by the undertaker. No cool room in that mortuary.

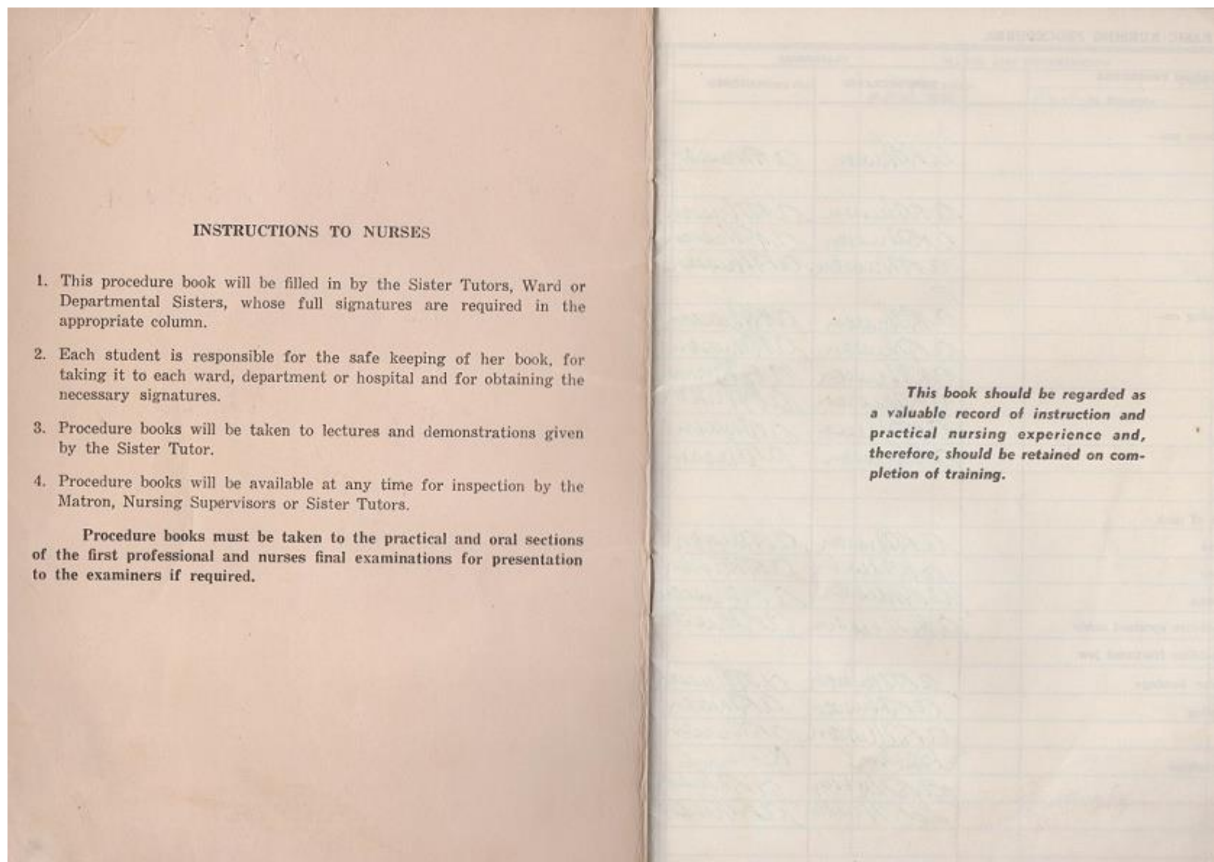
I was eighteen and in second year. I had laid this lady out by myself with only the help of the nurse in the ward next door when we transferred the body to the trolley. I coped OK with the ritual of laying out dead bodies, however the trip to the morgue was very spooky. The student nurse from the next ward was looking after both wards while I was doing the morgue duty. No security staff to give support in those days. There was no choice but to get on with the job as there was no other help. However, there was help fortunately on one night on the day that I returned after my father's death in December 1965. I was on night duty and one of my patients had died. My friends (the other students) on the other ward decided that they would look after the body and I could cover one of their wards. This was the nature of our close working relationships in a small hospital with few human resources other than our colleagues; a great way to learn about being a member of a team. (This reminds me of how we would always make sure that our friends had finished all of their work before any of us would go off duty.)

As I sit here and write this I can feel the emotion well up in me as it did then when I walked along the side of the building to go into what was now the café, which had been the female public ward. At that time, I could almost hear the ward noises as I sat there and drank my coffee (not something I ever did as a young nurse) and read the book about the hospital's history. I looked around the café and saw the artefacts of the past on the walls and remembered also working alone there and realised that those walls did not have the one thing expected today - piped oxygen and suction pipes.

I wondered what the ghosts of the past - nurses and patients, thought of this coffee drinking pastime?

APPENDIX 2: PROCEDURE BOOK





INSTRUCTIONS TO NURSES

1. This procedure book will be filled in by the Sister Tutors, Ward or Departmental Sisters, whose full signatures are required in the appropriate column.
2. Each student is responsible for the safe keeping of her book, for taking it to each ward, department or hospital and for obtaining the necessary signatures.
3. Procedure books will be taken to lectures and demonstrations given by the Sister Tutor.
4. Procedure books will be available at any time for inspection by the Matron, Nursing Supervisors or Sister Tutors.

Procedure books must be taken to the practical and oral sections of the first professional and nurses final examinations for presentation to the examiners if required.

This book should be regarded as a valuable record of instruction and practical nursing experience and, therefore, should be retained on completion of training.

Part I. BASIC NURSING PROCEDURES.

NURSING PROCEDURE	CLASSROOM: DEMONSTRATED	CLASSROOM: PRACTISED	WARDS AND DEPARTMENTS: DEMONSTRATED	PRACTISED (MIW / FW ND / FN)	CHW 1st Signature	PROFICI[ENT] MP
Indwelling catheter with drainage—(Continued) continuous	AKHusson	AKHusson				
condome drainage						
Charts— recording of bowel actions	AKHusson	AKHusson		✓ ✓ ✓ ✓	✓	
fluid and/or food intake	AKHusson	AKHusson		✓ ✓ ✓ ✓	✓	
fluid output	AKHusson	AKHusson		✓ ✓ ✓ ✓	✓	
Cleaning, general— bathroom	Lecture	Lecture				
cupboards	Lecture	Lecture		✓ ✓ ✓	✓	
flower room	Lecture	Lecture		✓		
lavatory	Lecture	Lecture		✓ ✓		
pan room	AKHusson	AKHusson		✓ ✓	✓	
sterilizer	Lecture	Lecture		✓		
sterilizing room	Lecture	Lecture		✓ ✓		
ward furniture	AKHusson	AKHusson		✓ ✓	✓	
Cold Applications— evaporating lotion						
ice	AKHusson	AKHusson				
starch poultice	Lecture	Lecture				
Counter Irritants— fomentations, medical	Lecture	Lecture				
liniments	AKHusson	AKHusson				
poultices PLASTINE	AKHusson	AKHusson		✓		
radiant heat	Lecture	Lecture		✓		
Disinfection of— blankets	Lecture	Lecture				
clothing	Lecture	Lecture				
cushions— air	Lecture	Lecture				
sponge rubber	Lecture	Lecture				
excreta	Lecture	Lecture		✓ ✓ ✓		
feeding utensils	Lecture	Lecture		✓ ✓		
linen	Lecture	Lecture				

Part I. BASIC NURSING PROCEDURES.

NURSING PROCEDURE	CLASSROOM: DEMONSTRATED	CLASSROOM: PRACTISED	WARDS AND DEPARTMENTS: DEMONSTRATED	PRACTISED (MIW / FW ND)	CHW 1st Signature	PROFICI[ENT] NO
Hot Water Bags—(Continued) method of filling	AKHusson	AKHusson				
precautions in use of	AKHusson	AKHusson				
Inhalations— medicated steam	AKHusson	AKHusson				
Lotions— dilution of	AKHusson	AKHusson				
storage of poisonous lotions	Lecture	Lecture				
Medicines— administration of simple medicines	AKHusson	AKHusson		✓ ✓	✓ ✓	✓
Mouth— routine care of	AKHusson	AKHusson		✓ ✓	✓ ✓	✓
special care of, in sick or helpless patients	AKHusson	AKHusson		✓	✓ ✓	✓
Nose— simple toilet	AKHusson	AKHusson			✓ ✓	
Oxygen— intranasal method	AKHusson	AKHusson		✓ ✓ ✓	✓	✓
care of equipment	AKHusson	AKHusson		✓ ✓	✓	✓
Patient Care— admission of—	AKHusson	AKHusson		✓ ✓ ✓	✓ ✓	✓
including care of effects	AKHusson	AKHusson		✓ ✓ ✓	✓ ✓	✓
including care of valuables	AKHusson	AKHusson		✓ ✓ ✓	✓ ✓	✓
discharge of	AKHusson	AKHusson		✓ ✓ ✓	✓ ✓	
transfer of, to another ward	AKHusson	AKHusson		✓ ✓	✓	
transfer of, to another hospital	AKHusson	AKHusson		✓ ✓ ✓	✓	
escort to and from operating theatre	AKHusson	AKHusson		✓ ✓ ✓	✓ ✓	
care during recovery from general anaesthetic	AKHusson	AKHusson		✓ ✓ ✓	✓ ✓	✓
general comfort including lifting and maintenance of correct position	AKHusson	AKHusson		✓ ✓ ✓	✓ ✓	✓
prevention of deformity	AKHusson	AKHusson		✓ ✓	✓ ✓	✓
sitting out of bed	AKHusson	AKHusson		✓ ✓ ✓	✓ ✓	
exercising of	AKHusson	AKHusson		✓ ✓ ✓	✓ ✓	
weighing of	AKHusson	AKHusson		✓		
Pediculosis— treatment of	AKHusson	AKHusson			✓	
Positions— dorsal	AKHusson	AKHusson		✓		

APPENDIX 3: REPORT OF COMMITTEE ENQUIRY INTO NURSING

Report of Committee of Enquiry into Nursing

In February 1965 the Victorian Nursing Council proposed a new curriculum for basic general training, with a minimum of 1,600 teaching hours. As a result of this initiative the Government established a Committee of Enquiry into Nursing in 1966.

The Committee brought down its Report in August 1970 and the R.V.C.N. Council has made a Submission to the Minister of Health, *which appears in this journal*, so that all nurses will have an opportunity of studying the criticisms made by their professional organization.

It is strongly recommended that nurses procure copies of this Report so that they may be conversant with its findings and it is hoped that study groups will be set up in Branches and Sections in order to study the Report in conjunction with the R.V.C.N. submission.

Further, the co-operation of nurses is sought in making known the contents of the R.V.C.N. Submission which means discussions with other nurses, approaching Members of Parliament and activating interested groups to give their support.

Copies of the Report can be obtained from the Department of Health, Revenue Section, 224 Queen Street, Melbourne, enclosing a remittance at the rate of $2.00 per copy. Those applying in person should go to the 8th floor.

APPENDIX 4: LETTER TO MINISTER

The Nurse Educators' Section

of

The Royal Victorian College of Nursing

431 St. Kilda Road
Melbourne. 3004

8th September, 1969.

The Hon. Vance Dickie, M.L.C.,
Minister for Health,
Health Department,
295 Queen Street,
MELBOURNE. 3000

Dear Mr. Minister,

As your committee of enquiry into basic nursing education was set up over two years ago, the members of the Nurse Educators' Section, Royal Victorian College of Nursing, anxiously await your findings. We consider that the whole question of an improved curriculum is urgent. Each year medical techniques and knowledge become more complex and consequently the demand for skilled, intelligent nursing care increases. Our endeavours to provide suitable personnel, capable of fulfilling this demand is hampered by a curriculum outdated by over 30 years.

According to a recent statement, reported in the Melbourne "Sun", 3rd July, Dr. Lindell proposed "raising the academic standard of the course, and placing emphasis on bedside teaching". We believe that this can only be done by implementation of the proposed curriculum. Whatever teaching is carried out at the bedside must be educationally planned, then implemented and supervised by suitably prepared registered nurses. Unless preparation is made now for the future, the standard of patient care will deteriorate.

... 2.

The Minister for Health   8th September, 1969.

- 2 -

The present staff establishment of schools of nursing, as stipulated by the Hospitals and Charities Commission is hopelessly inadequate and affords no opportunity to encourage and prepare potential nurse educators for any proposed improvement in curriculum content, either in theory or in clinical teaching.

Those of us who have daily contact with student nurses are becoming increasingly concerned because the wave of student unrest which is at present disrupting our schools and universities is also reaching them. This is largely brought about by the unreal demands made on their time and energy, and because they are currently ill equipped to carry the responsibility expected of them.

We therefore, Sir, urge you to consider our request for some indication of the findings of the committee of enquiry, and press for an early favourable decision regarding the implementation of the proposed curriculum for basic nursing education.

Yours faithfully,

Margaret A. Whitfield

Margaret A. Whitfield,
Chairman.

APPENDIX 5: RVCN 1970 LETTER TO PREMIER

COPY ONLY

ROYAL VICTORIAN COLLEGE OF NURSING

VICTORIAN BRANCH OF THE

ROYAL AUSTRALIAN NURSING FEDERATION

WHICH IS AFFILIATED WITH

THE INTERNATIONAL COUNCIL OF NURSES

PUBLISHERS OF "UNA"

ESTABLISHED 1902

TELEPHONE 26 1258

431 ST. KILDA ROAD.
MELBOURNE. 3004

The Rt. Honorable Sir Henry Bolte,
Premier of Victoria,
Parliament House,
Spring Street,
MELBOURNE. 3000

26th March, 1970.

My Dear Premier,

I am writing to ask you to receive a deputation from the Royal Victorian College of Nursing to discuss matters which have concerned nurses over a number of years.

We wish to discuss general nursing conditions and, in particular, modernisation of the existing training curriculum which is based on the curriculum laid down in 1928. The Victorian Nursing Council, as long ago as 1965, proposed and adopted a curriculum more in keeping with modern needs, and this received endorsement from the Royal Victorian College of Nursing.

Following this your Government established a Committee of Enquiry into Nursing in 1966. This Committee has not yet reported.

The College has approached your Minister of Health on a number of matters as recently as 2nd October, 1969, and it is not satisfied that its genuine concern has been sufficiently appreciated.

So great is the concern of the College over shortcomings within the profession, we are taking this unique step of seeking an interview with you as Head of the Government. It is our hope that after hearing our case you will feel yourself justified in giving an assurance in your policy speech that you will give immediate attention to repairing sagging morale within the profession by rectifying shortcomings in the curriculum and such other areas as you see fit.

The College will be holding a rally on Wednesday the 13th May, 1970, in the Assembly Hall in Collins Street, and we expect 1,000 nurses from all parts of Victoria to attend. You can be assured that any favourable response to our deputation will receive widespread publicity and acclaim.

Yours sincerely,

(Signed)
Mary Evans
President

APPENDIX 6: RVCN 1969 LETTER TO MINISTER FOR HEALTH

ROYAL VICTORIAN COLLEGE OF NURSING

VICTORIAN BRANCH OF THE

ROYAL AUSTRALIAN NURSING FEDERATION

WHICH IS AFFILIATED WITH

THE INTERNATIONAL COUNCIL OF NURSES

PUBLISHERS OF "UNA"

ESTABLISHED 1902

TELEPHONE 26 1258

431 ST. KILDA ROAD.
MELBOURNE. 3004

22nd August, 1969.

The Hon. Vance Dickie, M.L.C.,
Minister of Health,
Health Department,
295 Queen Street,
MELBOURNE. 3000.

Dear Mr. Dickie,

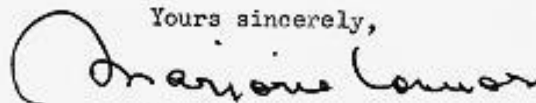
Over the months that you have been overseas, the members of the Council of the Royal Victorian College of Nursing have become increasingly disturbed about various aspects of nursing.

It was therefore resolved that, as soon as you returned, a request be made asking for you to receive a deputation concerning very urgent problems in the nursing profession.

It is hoped that, by making this approach as soon as you were back in office, it may be possible for you to see our representatives at an early date.

Trusting that you have had an interesting and profitable trip overseas,

Yours sincerely,



(Marjorie Connor)
Executive Secretary

APPENDIX 7: VNC 1972 LETTER TO RNS RE NEW CURRICULUM

VICTORIAN NURSING COUNCIL

(Nurses Act 1958)

ALL COMMUNICATIONS SHOULD BE ADDRESSED TO THE CHIEF NURSING OFFICER MISS M. MENZIES

437 ST. KILDA ROAD,
MELBOURNE, 3004
TEL.: 26 3231

June, 1972

Dear Registered General Nurse,

NEW GENERAL NURSING CURRICULUM

Most nurses holding practising certificates know that the Victorian Nursing Council has prepared a new curriculum for the training of general nurses, and that the programme for its adoption provides that it will be applicable to all who commence their training in 1974. The enclosed pamphlet is to ensure that all practising general nurses are aware of –

- the extent of the preparatory work which has already been done towards the introduction of the new curriculum
- the principles incorporated in it
- the progress being made towards its implementation.

Yours sincerely,

J. F. Patrick
Chairman

APPENDIX 8: 1971 SUBMISSION-COUNTRY & METROPOLITAN HOSPITALS.

JOINT SUBMISSION BY

THE COUNTRY HOSPITALS' ASSOCIATION

and

THE METROPOLITAN HOSPITALS' ASSOCIATION

concerning

FINANCIAL AND OTHER IMPLICATIONS ASSOCIATED WITH THE

IMPLEMENTATION OF A NEW CURRICULUM FOR GENERAL NURSE TRAINING

Watch country nurses

6th September, 1971

(1) Before Reps — select committee

Finance

Will funds be forthcoming

9 unit-2-yr

Genl cof.

Authority

Diversion of funds

Mr. Minister,

We wish to thank you for your willingness to see us on this occasion. Were it not for the fact that we believe that what we have to put to you is of the most vital importance we would not have sought the interview, for we realise that you have many important matters of State to engage your attention.

Sir, we approach you at this time in relation to the proposed new curriculum for general nurse training for we understand that the draft regulations are presently before you awaiting promulgation and we desire to place before you certain information which we believe must be taken into account prior to the actual and legal commencement of this important curriculum.

In the first instance, we wish to state that we do not oppose the introduction of a new curriculum for general nurse training. We recognise that in order to meet the community's needs of the future that we will be required to educate nurses to a higher standard than at present; to better prepare and equip them to cope with the ever changing and advancing field of medical technology and, generally, to ensure that patient care and nursing service are kept at the optimum level.

Both Associations have conveyed that expression to you in earlier written communications and we do not believe that more needs to be said of this at this time.

However, while we do in fact support the introduction of a new curriculum, such support is, and must be, qualified to the extent that its introduction is only possible if all the monies needed are made available by the Government. It is this particular matter of finance which causes us much concern at this time.

Sir, in speaking to the Institute of Hospital Administrators and its guests on Friday, 16th April, at Healesville, those present noted

with great satisfaction your assurance that the Government would make available all monies necessary, to ensure the full implementation of the curriculum which it had adopted as policy.

However, since that time, members of both Associations have been somewhat disturbed by the apparent anomaly between your remarks and the written comments to various institutions by your Hospitals and Charities Commission. As an illustration, we set out an example which we believe is representative of the advice tendered by the Commission to those institutions which have sought assurances relative to the question of financing the curriculum.

On 10th March, 1971, the Metropolitan Hospitals' Association wrote to the Hospitals and Charities Commission and stated, inter alia,

> "....the Association presumes, and seeks an assurance, that the necessary finance for the full implementation of the curriculum will be made available to member training schools and that the necessary finance will not be expected to be found out of normal capital allocations".

In a letter dated 20th April, 1971, the Commission replied as follows:-

> "The problems associated with implementing the new nursing syllabus and the cost involved were placed before the Honourable the Minister of Health for his consideration, and we will inform you when a decision is reached on the provision of funds.
>
> In the meantime, any additional expenditure incurred must be absorbed in the budget expenditure of the individual hospitals and met from the funds available to them at the time".

We are not, at this point in time, in possession of any further formal advice from the Hospitals and Charities Commission. However, from verbal communications which many of our representatives have had with Commission officers, we are led to believe that no additional monies are,

or will be forthcoming as far as is known by the Commission to meet the costs associated with the curriculum.

Prior to making our request of you in relation to the provision of funds, we believe it appropriate to place before you our estimates of the costs. Both Associations, some time ago, learned of a survey undertaken for the Hospitals and Charities Commission as to costs involved and we were advised informally that the estimate for the State was:-

$5,000,000 for additional maintenance

$1,500,000 for additional capital items

a total of $6.5 millions.

Believing this figure to be an understatement, both Associations requested their general nurse training school member institutions to supply as accurate an estimate as could be provided of the costs associated with the introduction of the curriculum. The estimates produced the following results:-

	COUNTRY	METROPOLITAN	TOTAL
Wages Costs including other Maintenance Costs	1,104,406	5,064,090	6,168,496
Capital Costs	511,100	2,419,163	2,930,263
	$1,615,506	$7,483,253	$9,098,759

These figures are known to be most conservative because, in most instances member institutions are not able to make an assessment as to all facets of the curriculum as they are not as yet known, nor have detailed plans as to affilitations with other institutions been worked out and placed before the Victorian Nursing Council for approval.

In addition, the costs associated with placing student nurses with say, the Royal District Nursing Service for up to four weeks, (buses to transport them to and from their training schools for example) cannot be estimated. Further, institutions such as Midwifery Training Schools (i.e.

Royal Women's and St. George's) cannot possibly estimate their costs at this stage until actual plans for training and placing of students are formulated. We also, of course, have the increases awarded to trained and student nurses last week - in some cases as high as 30% - which have not been included in the above figures.

For these reasons, we believe that the actual figures might be very much closer to $11 millions.

For your information, we set out some of the other statistics obtained from member institutions as to requirements which will have to be met:-

	At Least
No. of Additional Tutors required	100
No. of Additional Trained Nurses required	700
No. of Additional Student Nurses required	300
No. of Additional Nursing Aides required	250
No. of Additional other staff - e.g. clerical, cleaners, librarians, etc.	50
Total	1,400 approx.

Although we do not intend making a submission at this stage as to staffing, we do have some very real reservations, in the light of current nursing staff wastage and shortages, as to whether the necessary staff will be available even if the money and facilities are available.

As indicated earlier, we obtained this information on costs because we believed that the figures supplied to you and on which we presume you made your statement guaranteeing the provision of funds, were an understatement. We are sure you will agree.

Mr. Minister, in addition to requesting an assurance regarding the provision of funds, we also seek from you your authority to permit our member training schools and other institutions to immediately commence the preparation of the sketch plans and drawings associated with the building programmes necessary to house the additional tutors' offices, for the classrooms, demonstration rooms, for the additional nursing residential accommodation and, indeed, for all those ancillary items which are required and which the above figure of $2,930,263 for capital items represents.

In making this particular request Sir, we wish to state in the strongest possible terms, that we are completely opposed to any suggestion that those additional works should, in any way, interfere with the normal building or general development programme of our member institutions.

While we have said in quite clear terms that we support the introduction of a new curriculum, we make it equally clear that we do believe that implementation should not, in any way, affect the normal day to day financial operations of hospitals from either the viewpoints or capital or maintenance expansion programmes.

We believe there are a number of practical difficulties associated with the implementation of the proposed curriculum. We have, and are presently making, arrangements for our Matrons and Principal Nurse Educators to meet together to consider the technical aspects of the curriculum, the need to reconcile the educational requirements of the curriculum with the service needs of the hospital.

If we find that there are major or serious problems in this direction, we would appreciate the opportunity of further discussions with you.

APPENDIX 9: 1984 GOVERNMENT DECISION ON NURSING EDUCATION

NATIONAL STEERING COMMITTEE AND TASK FORCES
FOR
IMPLEMENTING "GOALS IN NURSING EDUCATION"

College of Nursing, Australia   Florence Nightingale Committee, Australia
Royal Australian Nursing Federation

National Convener
c/o College of Nursing, Australia
Suite 22, 431 St. Kilda Road,
Melbourne, Vic., 3004
Telephone: (03) 266 3425

Your Ref.:

Our Ref.: JFC:MY

11 September 1984

MEMORANDUM

TO: Advisers, Task Force Conveners

FROM: June F. Cochrane, National Convener

RE: GOVERNMENT DECISION ON NURSING EDUCATION

You can imagine my delight on learning of the announcement of 24 August when I returned recently from my overseas holiday.

Sincere congratulations and thanks go to all who have assisted us to gain this major political victory.

As some may not yet have seen the full text of the news release a copy is enclosed, together with an extract from Hansard of 4 September 1984. From these documents it can be seen that successful Commonwealth/State Government negotiations are crucial to the implementation process, so while one phase of the task is completed the next is just beginning.

It is anticipated that the CTEC recommendations for 1985-1987 triennium will be available by the end of September and I have advised the Federal Government that we expect a substantial number of places/funding to be allocated to basic nursing courses.

In the near future I expect to be able to advise you of the arrangements to conclude the activities of the National Steering Committee/Task Force structure now that the major objective for which it was established has been achieved.

CONGRATULATIONS   CONGRATULATIONS   CONGRATULATIONS

June Cochrane

Enclosures

EWS RELEASE BY THE MINISTER FOR HEALTH, DR NEAL BLEWETT, THE INISTER FOR EDUCATION AND YOUTH AFFAIRS, SENATOR SUSAN RYAN, ND THE MINISTER FOR EMPLOYMENT AND INDUSTRIAL RELATIONS, MR RALPH WILLIS.

GOVERNMENT ANNOUNCES DECISIONS ON BASIC NURSE EDUCATION

The Federal Government today announced its in-principle support for the full transfer of nurse education to Colleges of Advanced Education.

In a joint statement, the Minister for Health, Dr Neal Blewett, the Minister for Education and Youth Affairs, Senator Susan Ryan, and the Minister for Employment and Industrial Relations, Mr Ralph Willis, said that, subject to negotiations with the States and Territories of satisfactory transition and cost-sharing arrangements, the last intake into hospital-based courses would occur in 1990. The full transfer will be completed by 1993.

The Government expects that significant benefits will result from the transfer, including a better trained and more flexible nursing workforce, increased employment opportunities for qualified nursing personnel, increased educational and vocational opportunities, particularly for women, and an enhanced status for nurses to bring them into line with other health professionals.

Ministers emphasised that, in reaching the decision on timing of transfer, the Government's primary concern was to ensure that transfer of nurse education to tertiary institutions would be undertaken in an orderly, planned fashion phased in gradually over the transfer period.

Transfers at a faster rate than that approved in principle by the Government could create severe shortages of trained nurses because of the need to replace student nurses working in hospitals, and could overstretch resources in the educational institutions.

The Prime Minister has telexed State Premiers to inform them of the decision and to foreshadow the discussions in the near future on arrangements for appropriately phased transfers in response to State initiatives. Further details of arrangements will be announced following those discussions.

The Ministers said that this decision followed consideration by Cabinet of an Inter-departmental Committee report on Registered Nurse Education.

The Committee was established by the Government on 28 May 1984 to report on proposals for transferring nurse training from hospitals to CAEs, taking into consideration costs, health and education issues, and as well as status of women and employment and industrial relations issues which could arise from the transfer.

./2

The Committee consulted widely with all State and Territory Governments, and representatives of nursing organisations, as well as receiving many submissions on the issues involved.

In taking its in principle decision to support the transfer, the Government noted advice that such a transfer achieved health and educational objectives, and is consistent with policies on the status of women.

Strong views have been expressed to the Government that the transfer is essential because of the rapidly changing nature of hospital care, and the need for more highly qualified staff to provide an appropriate standard of care.

Increased demand for community nursing services combined with increased difficulties that the hospital based systems are encountering in balancing service requirements and the need for an appropriate level of formal training and relevant clinical experience also were highly influential reasons for the decision.

CANBERRA
Friday, August 24, 1984.

APPENDIX 10: 1984 MEMO-FINAL MEETING OF THE NATIONAL STEERING COMMITTEE

NATIONAL STEERING COMMITTEE AND TASK FORCES
FOR
IMPLEMENTING "GOALS IN NURSING EDUCATION"

College of Nursing, Australia Florence Nightingale Committee, Australia
Royal Australian Nursing Federation

National Convener
c/o College of Nursing, Australia
Suite 22, 431 St. Kilda Road,
Melbourne, Vic., 3004
Telephone: (03) 266 3425

Your Ref.:

Our Ref.: JFC:CB

MEMORANDUM

To: Advisers and Task Force Conveners

From: June F. Cochrane, National Convener

Re: Final Meeting of National Steering Committee with Advisers and Task Force Conveners - to be held in Melbourne on Monday, 10th December, 1984 - 10am-4pm

During October each of the three 'parent' organizations held meetings of their Executive Committee and I am now able to advise you of the arrangements for the above-mentioned meeting.

The purpose of the meeting is to review the progress made since the announcement of the Federal Government decision, to plan future strategies and to formally bring to a close the National Steeting Committee Task Force structure.

The meeting marks a major milestone in the history of Australian nursing and it is therefore hoped that as many as possible will attend. If any Task Force Convener is unable to be present arrangements should be made for a representative to come in her stead.

You are probably aware that the Commonwealth offer to the States and Territories was made at a meeting in Canberra. During the past two weeks, a Commonwealth Government negotiating team, led by Mr. Tony Greville, has visited each Capital city for further discussions with State Government counterparts.

The terms of the Commonwealth offer, (copy attached), make it clear that from here on most of the activity needed to ensure the achievement of the total transfer of basic nurse education to the higher education sector by 1993 will need to be undertaken at State/Territory level. The meeting on 10 December will provide a forum for discussing the machinery planned or already established, both at governmental level and by the nursing organizations.

cont.../

Venue for meeting: Room 4.15, 4th Floor,
School of Nursing,
Lincoln Institute of Health Sciences,
2 Slater Street (formerly Arthur Street)
MELBOURNE.

Date: 10th December, 1984

Time: 10am - 4pm (approx.)

In order to enable Air Tickets and catering to be arranged, please advise me by Monday, 19 November if you are NOT able to attend the meeting.

I hope to see you there.

June Cochrane

Attachment - Commonwealth Offer

COMMONWEALTH OFFER

- The Commonwealth offer is based on the assumption that States will follow New South Wales model and contract with CAE's (through State advanced education authorities) for the provision of basic nurse education courses
- a Commonwealth per capita payment for transfers up to the Commonwealth agreed rate of transfer
- the grant of $1 500 (in December 1983 prices) in real terms: to be indexed by CTEC using the CAE funding index
- the grant will be paid to the States as a specific purpose payment - this would be readily identifiable
- the grant will be paid on a regular basis; the amount to be based on an annual CAE census figure
- TEAS allowance will be paid by the Commonwealth to all eligible nursing students.
- the Commonwealth offer is to provide TEAS and per capita grants for up to 5 000 places per annum by 1987 and conditional on the transfer causing minimum disruption in both the health and education sectors
- these places are additional to the 1 200 CAE places already funded through CTEC
- if the rate of transfer in a State exceeds that which the Commonwealth has agreed to support, TEAS would still be paid by the Commonwealth but on the basis that the excess would be recouped by reducing the aggregate per capita grant
- both TEAS and the per capita grant are subject to the conditions of
  - State funded capital program at a level acceptable to the Commonwealth program and
  - places being within the agreed rate of each State
- Commonwealth will provide some assistance to the States for retraining/refresher courses to assist in meeting shortages.

APPENDIX 11: 1976 ROYAL MELBOURNE HOSPITAL – LETTER

.l address:
. Post Office:
ne Royal Melbourne Hospital,
Vic..ria. 3050

Location
Grattan Street,
Parkville, Victoria,
Australia.
Telephone: 347 7111

Victoria's first hospital

THE ROYAL MELBOURNE HOSPITAL

RECEIVED
24 AUG 1976
MINISTER'S OFFICE

16th August, 1976.

The Honourable W. V. Houghton,
Minister of Health,
Department of Health,
555 Collins Street,
MELBOURNE 3000.

Dear Mr. Minister,

At the meeting of the Board of Management of this Hospital held on 10th August, 1976, the first report of the Committee on Nursing Manpower of the Hospitals and Charities Commission was discussed.

The report deals in essence with the effect of the 1600 hour nurse training curriculum and the provision of additional beds in the State of Victoria on the ability of hospitals to maintain adequate nurse staffing levels.

It was noted that this Hospital is approaching 1300 hours of nurse training and is experiencing extreme difficulty in maintaining a satisfactory level of nursing cover in ward areas. This has resulted in closure of beds when major troughs occur in nursing staff availability, and this situation will be exacerbated as we continue to move towards the full 1600 hours of training as prescribed.

The Board of Management is deeply concerned with the unfavourable trends disclosed in the report and their anticipated effect on the operation of this Hospital, and has requested that the matter be drawn to your attention as a matter of urgency.

It is our belief that other hospitals operating nurse training schools could be experiencing similar difficulties to those I have outlined above, and that the Government should be acquainted with this situation with a view to initiating positive remedial action.

Your early and favourable attention to this matter is earnestly requested.

Yours sincerely,

J. L. Frew,
PRESIDENT.

APPENDIX 12: ADELAIDE ADVERTISER 1980 ARTICLE

"Nurses march in protest"

Nurses march in protest

Five-hundred off-duty nurses marched through Adelaide last night to protest at nursing education.

The nurses, some dressed in Florence Nightingale uniforms and carrying lamps, marched from Parliament House to their headquarters in Kent Town.

They carried banners with messages such as: "Florence N was more progressive han us." and "Nursing out of the Dark Ages."

They were led by the president of the SA branch of the Royal Australian Nursing Federation, Miss Joan Durdin.

After the march Miss Durdin, who is also head of the nurse training program at the Sturt College of Advanced Education, said the nurses felt their training and education programs were not progressing.

A Federal Cabinet decision to reject most recommendations of a Government committee of enquiry into nurse education and training and the possible closure of the Sturt college, were mainly responsible for the feeling.

Transfer decision

The Tertiary Education Authority of SA had recommended that Sturt college be closed and that higher education nursing programs taught at Sturt be transferred to Flinders University.

Miss Durdin said a decision on Sturt would not be made until September and nurses would "keep the issues before the public" until then.

Nurses wanted more professional training to improve nursing care.

"We have seen the benefits that come to nursing when nurses are trained to think for themselves, to relate comfortably with the other people with whom they work, doing their job with confidence and being trained to be advocates of the patient," Miss Durdin said.

"Nurses spend more time with patients than any other health professionals and it is essential they be adequately trained for the role.

"The present system of training in but prevents nursing students from learn- hospital focuses on the care of the sick, ing skills essential to communicating with the patient, putting their knowledge to best advantage and giving greater depth to nursing.

Miss Durdin said she had seen 144 nurses graduate from Sturt college in three years.

As a result of this training they had extra skills, confidence and ability to perform their jobs.

It was a "narrow, short-sighted and ignorant view" to say nurses did not need extra education for their role and that moves towards achieving it were motivated at gaining more status for nursing.

Carrying old lanterns and wearing full-length skirts yesterday were Matron I Deal and nursing lecturer R. C. Harrington.

APPENDIX 13: TIMELINE OF CHANGE IN NURSING EDUCATION 1964-1994-COMPARISON

Year	Professions involvement in nursing education	Author's engagement in nursing education
1960s to 1970s	• All States hospital-based education • Victoria 800 hours class room – 3-year certificate • Students predominantly labour force of hospitals • 1965 Victorian Nurse Educators RVCN proposed a new curriculum for basic general training with an increase to 1600-hour teaching time. • RVCN concerned that student nurses were critical to hospital workforce rather than being predominately treated as nursing student.	• Trained in a Victorian hospital to become a registered nurse in hospital-based certificate course 1964-1967. • Graduated believing I did not have enough skill and knowledge to be a good registered nurse. • Principal Tutor of the hospital-based program of my training school was involved in lobbying by the Victorian Nurse Educators RVCN.
1971	• Employers concern re impact of predicted increased classroom hours on hospital staffing. Prediction would need to employ more registered nurses	• Employed as registered nurse in New South Wales and Victoria
1972	• Minister of Health Victoria -announced increase in classroom hours to commence in 1974	• Employed as registered nurse in Victoria
1973	• Establishment of National Task Force for Goals in Nursing Education 1975-1991 – for transfer of nursing education to higher education sector	• Saw clinical teaching for the first time in New South Wales hospital
1974	• Hospital-based curriculum hours increased to 1600 in Victoria -Certificate • First Victorian pilot college diploma program commenced • First year of binary system of education in Victoria	• Employed as registered nurse in New South Wales

1975	• South Australian hospital-based certificate courses increased to 1000 hours curriculum • First South Australian pilot college-based program commenced- Diploma • First year of binary system of education in South Australia and Western Australia	• Employed as agency registered nurse in Victoria
1976/1977	• New South Wales hospital-based certificate courses increased to 1000 hours curriculum	• Moved to South Australian hospital as registered nurse and employed in South Australia. • 1977 undertook first orientation program - learnt about the changes occurring in nursing education
1978	• First graduates from South Australian Pilot Program – Diploma	• Undertook First Year Registered Nurse Course in South Australian hospital
1979-1980	• March by members of the profession to keep Sturt College of Advanced Education open • Hospital-based students being released from ward cleaning	• Commenced Diploma of Teaching (Nurse Education) at Sturt College of Advanced Education -1979-80 • Attended the march for keeping Sturt open 1980 • Employed in first teaching role as hospital- based clinical teacher in South Australia. • Introduced to research in nursing
1983	• New South Wales announces full transfer of pre-registration nursing course to the Higher Education Sector	• Completed Bachelor of Education (Nursing Studies) In South Australia • Tutor in hospital-based nursing course in South Australia
1984	• May- College of Nursing Australia Conference – Burning of Sax Report and march by nurses to Federal Health Ministers office • August - Health Announcement by Federal Government of in-principle support for transfer of all nursing education into higher education sector • Task Force for Goals in Nursing Education disbanded announcing that their objectives had been achieved	• Employed as in-service educator running first-year registered nurse course. • Using research evidence to change practice. • Attended my first nursing conference and is involved in the march to Australian Health Minister's office with burnt Sax Report.

1985	• First cohort of college-based students graduate from South Australian College of Advanced Education	• Running combined first-year education course for first graduates of the South Australian college and the hospital graduates
1987	• Announcement by Federal Government to abolish 'advanced education sector' with amalgamation of Universities and Colleges of Advanced Education. • Last intake of hospital-based courses New South Wales.	• Employed in first academic teaching role, South Australian College of Advanced Education
1990	• Last intake of hospital-based in Queensland • Last graduation of hospital educated registered nurses in New South Wales	• Director of Nursing Regional Hospital in South Australia 1990 -1991 • Graduated Master of Nursing Administration (UNSW) 1990
1991	• Amalgamation of Australian Universities and Colleges of Advanced Education	• Moved to work in Indonesia 1991-1993 establishing new private hospital in Jakarta • Publication: Hills-Siegloff & Walker - 'Developing a new reality from strong foundations'
1993	• All nursing preregistration programs in Australia transferred to the higher education sector • No further hospital-based pre-registration nursing certificate course intakes in Australia. • South Australian College of Advanced Education Sturt Campus Amalgamated with Flinders University	• District Director of Nursing in Regional New South Wales 1993-1995
1994-1996	• Publication Reid 1984 'Nursing Education in Australian Universities' Reid encouraged nurses to engage in research to strengthen their professional engagement.	• Read Reid publication to update my knowledge about what was occurring in nursing education in Australia. • University lecturer role in Victoria from 1996

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